AETNA HEALTH OF CALIFORNIA INC.

Group agreement

The HMO agreement is by and between

AETNA HEALTH OF CALIFORNIA INC.
(Aetna, we, us, or our)
and
LIGHTING RESOURCES, INC.
(**Contract holder**, you, or your)

Group agreement number: 0801556
Effective date: January 01, 2019

This HMO agreement takes effect on the **effective date** if we have received your signed group application and the initial premium. It remains in force until terminated.

Term of the HMO agreement: The initial term shall be the 12 consecutive month period beginning on the **effective date**.
Subsequent terms shall be the 12 consecutive month period beginning with the **renewal date**.

Premium due dates: The **effective date** and the 1st day of each succeeding calendar month.

Signed at **Aetna's** Home Office. 1385 East Shaw Ave, Fresno, CA 93710.

By: Gregory S. Martino

Gregory S. Martino
Vice President

Table of contents

The HMO agreement

The HMO agreement consists of several documents taken together. These documents are:

- Your group application
- This group agreement
- The EOC(s) attached
- The schedule of benefits attached
- Any riders and amendments to the group agreement, the EOC, and the schedule of benefits

If you want to discuss your coverage

If you have questions about your coverage under the HMO agreement, or if you wish to discuss it, contact your agent. If you did not use an agent to purchase your coverage, or if you have additional questions, you may contact us at:

Aetna
1385 East Shaw Ave
Fresno, CA 93710
1-800-445-5299

Please have your group agreement number available when you contact us. It is on the front page of this group agreement.

Glossary

You will see some words in bold type in the HMO agreement. The bold type means we have defined those words. The definitions are in this section and in the *Glossary* section of the EOC.

Contract holder

LIGHTING RESOURCES, INC. and entities associated with it for purpose of coverage under this HMO agreement.

Covered person

An employee or a dependent of an employee for whom all of the following applies:

- The person is eligible for coverage as defined in the EOC
- The person has enrolled for coverage and paid any required premium contribution
- The person's coverage has not ended

Dates:

Effective date

Date we first cover you under this HMO agreement.

Final rates and fees schedule effective date

Date stated on the *Final rates and fees schedule*.

Premium due date

The **effective date** and the 1st day of each succeeding calendar month.

Renewal date

Date that is 12 months after the **effective date** and each 12 month date thereafter.

Termination date

The date coverage ends according to the *Termination* section.

Premium

Premium – rates and amount due

The premium rates are stated in the final rates and fees schedule. We will provide you with a new final rates and fees schedule if and when the premium rates change. Any new schedule will state its **effective date**.

We charge premium based on the premium rates in effect on the **premium due date**.

The premium due on any **premium due date** is the sum of the premium charges for the coverage we provide. When we calculate premium due, we will use our records to determine who is a **covered person.**

You owe premium for a **covered person** starting with the first **premium due date** on or after the day the person's coverage starts. You stop paying premium for a **covered person** as of the first **premium due date** on or after the day the person's coverage ends.

Premium – individual proration

Premium shall be paid in full for persons who are covered for an entire month beginning with the **premium due date.**

Premiums shall be adjusted as outlined below for persons whose:

- Coverage is effective on a day other than the first day of the billing month or
- Coverage terminates on a day other than the last day of the billing month

If a person's coverage starts between the 1st through the 15th of the month, the premium for the whole month is due. If the coverage starts between the 16th through the 31st of the month, no premium is due for the month.

If a person's coverage ends between the 1st through the 15th of the month, no premium is due for that month. If the coverage ends between the 16th through the 31st of the month, the premium for the whole month is due.

Premium – changes in rates

We may change the premium rates as of a premium due date during the initial term only if:

- There is a change in factors that materially affects the risk we assumed with this coverage. We identify these factors in our rate quote to you
- There is a change in federal and state laws or regulations, or there is a judicial decision, that materially affects the cost of providing coverage

We may change the premium rates as of a **premium due date** during any subsequent term.

We will provide 60 days prior written notice to you of any change in premium rates.

Premium – experience credit

We may declare an experience credit at the end of a plan year. We do not have to declare any experience credit.

If we declare an experience credit, we may return the amount of the credit to you:

- By electronic fund transfer
- By application of the amount to premium due in the current or succeeding plan year, or
- By any other manner that we and you agree to

We can require you to share an experience credit with your employees in a manner reasonably acceptable to us, as a condition of our giving the credit. If the sum of employee contributions for coverage exceeds the sum of premium paid less any experience credits, we will require you to apply at least the excess experience credit for the sole benefit of employees.

Premium – when due

Premium is due on the **premium due date**.

You have a payment grace period of 31 days immediately following the **premium due date**. The HMO agreement will remain in force during the grace period. If we have not received all premium due by the end of the grace period, this HMO agreement will automatically terminate at the end of the grace period.

Premium – how billed and paid

We may bill you electronically. You shall pay premium due by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Premium – overdue amounts

We may recover from you the costs of collecting any unpaid premium, including reasonable attorney fees and costs of suit.

Premium – eligibility corrections

We will retroactively drop a **covered person** from coverage and credit to you premium payments if:

- We billed you based on eligibility information you provided us
- The eligibility information included a person who was not eligible for coverage
- You request that we retroactively drop the person from coverage, and
- The person did not pay the required premium contribution for the period

Our credit of premium is limited to 2 month's credit for a person whose loss of eligibility occurred more than 30 days before the date you notified us. We may reduce the credits by the amount of any benefit payments we may have made on behalf of such persons before you notified us that the person was not eligible for coverage.

Your request that we retroactively drop coverage is your representation that the person did not pay the required premium contribution for the period.

We will retroactively cover eligible persons whom you did not include in the eligibility information you provided us. We will cover them retroactively no more than 30 days before the date you both notify us and pay all applicable past premium.

Premium – waiver

Payment of premiums

We may waive up to one month's billed premium payments during any HMO agreement term.

The premium waiver will not apply for those employees :

- If after that month's premium has been billed, employees are added or removed from the plan coverage.
- For that month of coverage, additional premium will be due or credited.

Repayment of the waived premium

We may require you to pay back the premium waived if the group agreement is terminated within 12 months of your original **effective date**. We will give 10 days prior written notice to you of the requirement for the repayment of the waived premium.

Fees for special services and assessments

Special services

You may request that we provide special services beyond the routine administration of this HMO agreement. We will charge you a fee for each special service we provide.

The special services are:

- Our billing you for amounts due in a non-electronic medium
- Our accepting payment of amounts due from you other than by electronic fund transfer. If you pay us by check, the check does not constitute payment until it is honored by a bank
- Our handling your check returned to us due to insufficient funds. We may return the check to you without a second attempt to cash it
- Reinstatement of the HMO agreement according to the *Termination* section
- Any other special service you request and we agree to provide

Special services – fees

The special service fees are stated in the final rates and fees schedule. We may change any fee on 30 days advance notice to you. We will provide you with a new final rates and fees schedule if and when the amount of any fee changes. The new schedule will state its **effective date**.

Assessments

We may charge you a pro rata allocation of any assessments we receive for state high risk pools and other state programs.

Fees and assessments – when due

Fees and assessments are due on the **premium due date** immediately following our invoicing you.

You have a payment grace period of 31 days immediately following the **premium due date**. The HMO agreement will remain in force during the grace period. If we have not received all fees and assessments due by the end of the grace period, this HMO agreement will automatically terminate at the end of the grace period.

Fees and assessments – how billed and paid

We may bill you electronically. You shall pay fees and assessments by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Fees and assessments – overdue amounts

You shall pay us interest on the total amount of fees and assessments that is overdue. Overdue fees and assessments include amounts due but not yet paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

We may also recover from you the costs of collecting any unpaid fees and assessments, including reasonable attorney fees and costs of suit.

Some of our other responsibilities

We will prepare the EOC and schedule of benefits that are part of the HMO agreement, as required by applicable federal and state laws. We will provide them to you in electronic form. We will also provide them to you in paper form if you request it.

We will provide the coverage stated in the EOC and schedule of benefits that are part of the HMO agreement. We will administer the coverage as required by the HMO agreement and applicable federal and state laws.

We will protect the personal health information of **covered persons** as required by federal and state laws. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help us process **providers**' claims and otherwise help us administer the HMO agreement. For a copy of our Notice of Privacy Practices, call the toll-free Member Services number on your member ID card or log on to www.aetna.com.

Our duties in this *Some of our other responsibilities* section survive termination of the HMO agreement.

Some of your other requirements and responsibilities

Participation and contribution

You must comply with our participation and contribution requirements.

Distribution – certain Patient Protection and Affordable Care Act (ACA) requirements

You shall distribute two documents required by the federal ACA:

- Summary of benefits and coverage (SBC)
- Notices of material modifications

You shall distribute them to your employees and their dependents, in accordance with the federal delivery, timing, and trigger requirements.

You shall certify to us on an annual basis and upon our request, that you have distributed them and will distribute them consistent with the ACA. You shall give us your certification within 30 calendar days of our request.

You shall give us information or proof upon our request, that you have distributed them and will distribute them consistent with the ACA. The information or proof must be in a form we will accept. You shall give us the information or proof within 30 calendar days of our request.

Your duties and our rights in the ACA requirements provision survive termination of the HMO agreement.

Distribution – certain Employee Retirement Income Security Act (ERISA) of 1974 requirements

You are responsible for creating and distributing all reports and disclosures required by ERISA. These include:

- Summary plan descriptions
- Summary of material modifications
- Summary annual reports

Distribution – EOC and schedule of benefits

You will distribute as required by applicable federal and state laws, the EOC and schedule of benefits that we provide you.

Information – access

You shall make payroll and other records directly related to a person's coverage under this HMO agreement available to us for inspection. This will occur:

- Upon our reasonable advance request
- At our expense
- At your office
- During regular business hours

Your duties and our rights in the Information – access provision survive termination of the HMO agreement.

Information – eligibility

You shall send us eligibility information we request to administer the HMO agreement. We will request the information monthly or as otherwise required. You will send us the information on our form, or through such other means as we require.

The eligibility information includes but is not limited to data needed to:

- Enroll your employees and their dependents
- Process terminations
- Make changes in family status

By sending the information to us you represent that it is correct. You acknowledge that we can and will rely on the information.

You shall:

- Maintain a reasonably complete record of the information you send us for at least seven years, and until the final rights and duties under the HMO agreement have been resolved.
- Send us information you sent us before, upon request.

We will not start covering a person under the HMO agreement until you send us the information to enroll that person. Subject to applicable federal and state laws and the HMO agreement, we will not stop covering a person until you send us the information to terminate coverage.

You shall notify us within 15 business days of the date in which:

- An employee's employment ceases, or
- A dependent loses eligibility under the HMO agreement

You must notify us when a request for retroactive termination is a result of a **covered person**:

- Performing an act or omission that constitutes fraud, or
- Making an intentional misrepresentation of material fact

to get coverage or to get a benefit under the HMO agreement.

Your duties and our rights in this Information – eligibility provision survive termination of the HMO agreement.

90 day waiting period limitation

Your plan can't have a waiting period of more than 90 days. That means employees and their dependents must be able to begin health coverage within 90 days. This is a requirement of the Affordable Care Act. It applies both to you and to us.

You will give us effective dates for your employees and their dependents that take into account all state and federal waiting period requirements. You acknowledge that we will rely on this information. You will inform us immediately if this information changes.

We will use this effective date information to enroll eligible employees and their dependents into the group plan.

Notices – termination of coverage

You shall notify **covered persons** in writing, of their rights when coverage stops.

In particular, you shall notify all eligible **covered persons** of their right to continue coverage pursuant to the *Special coverage options after your plan coverage ends* provisions in the EOC and applicable federal and state laws. Your notification will include:

- A description of plans available
- Premium rates
- Application forms

You will give the notification within 60 calendar days of a person becoming eligible for continuation coverage.

Your duties and our rights in this Notices – termination of coverage provision survive termination of the HMO agreement.

Workers' compensation coverage

You must comply with workers' compensation coverage laws applicable to your employees covered by the HMO agreement. Prior to the **effective date** and upon our request after the **effective date** you will provide us reasonable evidence of your satisfying applicable workers compensation coverage laws.

You will provide us with monthly reports of all workers' compensation coverage cases. The report will list for each case, the employee name, identifying number, date of loss and diagnosis.

Termination

Automatic termination

The HMO agreement and all coverage end as of the last day of the grace period if you have not paid us all premium due as of the beginning of the grace period. The grace period is described in the *Premium* section.

The HMO agreement and all coverage end as of the last day of the grace period if you have not paid us all premiums and fees and assessments due as of the beginning of the grace period. The grace period is described in the *Fees for special services and assessments* section.

Termination by you

You may end coverage under this HMO agreement if you give us 30 days advance written notice. Your termination notice may apply to all classes or any class of your employees covered under the HMO agreement. You can send us a termination notice during a period for which you have paid premium, but your **termination date** must be after that period.

Termination by us

We may end the HMO agreement and all coverage it provides:

- Immediately upon notice to you:
  - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage
  - If you no longer have any employees under the plan who live, reside, or work in the service area
  - If you are a member of an association and your membership in the association ceases

- Upon 30 days written notice to you:
  - If you breach a provision of the HMO agreement and you do not cure the breach within the notice period
  - If you cease to be a group as defined under applicable state law
  - If you fail to meet our contribution or participation requirements applicable to this HMO agreement
  - If you do not certify your compliance with our policies and procedures upon request
  - If you change your eligibility or participation requirements without our consent

- Upon 90 days written notice to you (or such longer notice period as applicable federal and state laws requires,) if we cease to offer the product line provided by this HMO agreement

- Upon 180 days written notice to you (or such longer notice period as applicable federal and state laws requires,) if we act as required by applicable federal and state laws for uniform termination of coverage

We may rescind the HMO agreement and all coverage it provides for fraud or intentional misrepresentation of material fact upon 30 days advance written notice. The notice will state the **effective date** of rescission. You have the right to appeal our decision to rescind the HMO agreement and its coverage. Your appeal rights are:

- You have the right to an **Aetna** appeal.
- You have the right to a third party review conducted by an independent external review organization.

Non-renewal for failure to respond

We may request that you tell us whether you intend to renew the HMO agreement. You must reply:

- Within two weeks of your receipt of the request or
- Within 15 days prior to the **renewal date**

whichever is later. Your reply must be in writing unless we authorize an oral reply. If you do not reply, we will continue coverage on and after the **renewal date** and you will owe premium.

Effective time of termination

The HMO agreement and its coverage end at 11:59 p.m. on the day of termination.

Effect of termination

You, **covered persons**, and we continue to be responsible following termination for the duties we each incur prior to the termination of the HMO agreement. One of your duties includes payment of premium due for coverage through any grace period up to the day of termination. You, **covered persons**, and we also continue to be responsible for your, their, and our duties that the HMO agreement states are to occur following termination.

You, **covered persons**, and we have the rights and duties following termination of the HMO agreement, as stated specifically in the HMO agreement.

You shall notify **covered persons** of the termination of the HMO agreement. Your notice will comply with applicable federal and state laws. We have the right to notify employees of termination of the HMO agreement

Reinstatement

You may request that we reinstate the HMO agreement and coverage after we end it. You must make the request within 30 days of the **termination date**. We will reinstate the HMO agreement as of the **termination date** upon payment of all amounts due and you giving us reasonable assurances that you can and will fulfill all of your obligations under the HMO agreement.

Intentional deception

If we learn that you or a **covered person** defrauded us or that a **covered person** intentionally misrepresented material facts, we can and may take actions that can have serious consequences for coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward
- Denial or termination of benefits
- Recovery of amounts we already paid

We also may report fraud to federal and state law enforcement.

Rescission means you or a **covered person** loses coverage both going forward and going backward. If we paid claims for past coverage, we are entitled to the money back.
You have special rights if we rescind all coverage under the HMO agreement:

- We will give you and your employees who are **covered persons**, 30 days advance written notice of any rescission of coverage.
- You have the right to an **Aetna** appeal.
- You have the right to a third party review conducted by an independent external review organization.

A **covered person** has special rights if we rescind coverage just for that individual:

- We will give the **covered person** 30 days advance written notice of any rescission of coverage.
- The **covered person** has the right to an **Aetna** appeal.
- The **covered person** has the right to a third party review conducted by an independent external review organization.

Responsibility for conduct

Employees and agents

We are responsible to you for what our employees and other agents do.

We are not responsible to you for what is done by others, such as **providers**. They are not our employees or agents. **Providers** in our **network** are what the federal and state laws call our independent contractors. That simply means we have a business relationship with them and they are not our employees or agents.

Indemnification – in general

We agree to indemnify and hold you harmless against that portion of your liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by our willful misconduct, criminal conduct or material breach of this HMO agreement.

You agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your negligence, breach of the HMO agreement, breach of applicable federal and state laws, willful misconduct, criminal conduct, fraud, or your breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this HMO agreement or your role as employer or Plan Sponsor, as defined by ERISA.

These indemnification obligations end with the HMO agreement, except as to any matter concerning a claim that has been made in writing within 365 days after termination.

Indemnification – federal law requirements

You shall indemnify us and hold us harmless for our liability that is directly caused by your:

- Negligence
- Breach of the HMO agreement
- Breach of federal or state laws that apply or
- Willful misconduct

and your act or failure to act was related to or arose out of your obligation to deliver the Summary of benefits and coverage and Notices of material modification.

Your and our rights and duties in this *Responsibility for conduct* section survive termination of the HMO agreement.

General provisions

General provisions – content and interpretation of the HMO agreement

Applicable law

Applicable law means all federal and state laws that apply to the matters covered by the HMO agreement. Federal and state laws mean statutes, regulations, official agency direction and guidance, and judicial decisions and orders, as they may be passed or issued, or as they may be amended, from time to time.

Compliance with law

You and we shall interpret the HMO agreement if possible so it complies with applicable federal and state laws.

If the HMO agreement omits or misstates any right or duty under applicable federal and state laws, you and we shall implement the HMO agreement as though the right or duty is stated correctly in the HMO agreement.

If any provision of the HMO agreement is invalid or illegal, you and we shall implement the HMO agreement as though the provision is not in the HMO agreement.

Changes to the HMO agreement

The HMO agreement may be amended by a writing to which we both consent.

We may change or end some or all coverage under this HMO agreement by notice, if we act as required by applicable federal and state laws for uniform modification of coverage and uniform termination of coverage.

We may amend the HMO agreement by notice. We must give you 30 days advance written notice. Our amendment:

- Will not reduce benefits or coverage

- Will not eliminate benefits or coverage or
- Will not increase benefits or coverage with a concurrent increase in premium during the current HMO agreement term, other than increased benefits or coverage required by federal and state laws

Payment of the applicable premium on the **effective date** of any amendment is your consent to any amendment requiring your consent.

Changes to the HMO agreement do not require the consent of any employee or of any other person.

Entire agreement

The HMO agreement replaces and supersedes:

- All other prior agreements of HMO coverage between us
- Any other prior written or oral understandings, negotiations, discussions or arrangements between us related to this HMO coverage

Waiver

Only an officer of **Aetna** may waive a requirement of the HMO agreement.

We may fail to implement or fail to insist upon compliance with a provision of the HMO agreement at any given time or times. Our failure to implement or to insist on compliance is not a waiver of our right to implement or insist upon compliance with that provision at any other time or times.

General provisions – administration of the HMO agreement

Aetna name, symbols, trademarks and service marks

We control the use of our name and of our symbols, trademarks and service marks presently existing or subsequently established. You shall not use any of them in advertising or promotional materials or in any other way without our prior written consent. You shall stop any and all use immediately upon our direction or upon termination of the HMO agreement.

Assignment and delegation

You shall not assign any right or delegate any duty under the HMO agreement unless we approve it in writing in advance.

We may delegate some of our functions under the HMO agreement to third parties. We may also change or end these delegations. We do not need to give you advance notice to enter into, change or end these arrangements, and we do not need your consent.

Claim determinations – ERISA claim fiduciary

We are a fiduciary for the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974. We have complete authority to review all denied claims for benefits under this HMO agreement. In exercising this fiduciary responsibility, we have discretionary authority:

- To determine whether and to what extent **covered persons** are entitled to benefits
- To construe any disputed or doubtful terms under the HMO agreement. We shall be deemed to have properly exercised our authority unless we abuse our discretion by acting arbitrarily and capriciously.

Our review of claims for benefits may include the use of software and other tools to take into account factors such as:

- An individual's claim history
- A provider's billing patterns
- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

Correcting our administrative errors

A clerical error in keeping records or a delay in making an entry will not alone determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in premium if correction of the error or delay changes coverage.

We may correct, withdraw, or replace the group agreement, any EOC, any schedule of benefits and any other document issued with an error or issued in error.

Correcting your honest mistakes

If you or any employee makes an honest mistake of fact, we may make a fair change in premium. If the misstatement affects the existence or amount of coverage, we will use the true facts to determine whether coverage is or remains in effect and its amount.

Discrimination prohibited

You shall not encourage or discourage enrollment in the coverage provided by the HMO agreement based on health status or health risk.

You shall act so as not to discriminate unfairly between persons in like situations at the time of the action.

Notices

The HMO agreement requires or permits notice to each other. These notices shall be in writing.

Notice may be delivered:

- In person, and is effective upon delivery
- By United States mail, sent first class, postage prepaid, and is effective three U.S. Postal Service delivery days following the date of mailing
- By commercial carriers UPS and FedEx, effective upon delivery or
- By e-mail, facsimile or other electronic means, effective upon sending

Notice sent to us by mail and commercial carrier shall be sent to:

Aetna
1385 East Shaw Ave
Fresno, CA 93710 1-800-445-5299

Notice sent to you by mail and commercial carrier shall be sent to:
LIGHTING RESOURCES, INC.
805 E FRANSIC STREET

ONTARIO, CA 91761

You and we must designate specific e-mail addresses, facsimile numbers or other electronic means in writing for purpose of notices.

Policies and procedures

We have the right to adopt reasonable policies, procedures, rules, and interpretations of the HMO agreement in order to promote orderly and efficient administration. You and all **covered person**s are bound by and shall comply with them. You will certify your compliance with them upon our request or as required specifically by the HMO agreement.

Third parties rights

This HMO agreement does not give any rights or impose any duties on third parties except as specifically stated.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-982-3862.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance

TTY: 711

For language assistance in English call 1-888-982-3862 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862 . (Spanish)

欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad. (Tagalog)

T’11 sh7shizaad k’ehj7bee sh7k1 a’doowo[n7h7zingo Din4 k’ehj7koj8 t’11 j7k’e h0lne’ 1-888-982-3862 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an. (German)

Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862. (Albanian)

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للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862. (Acibar)

Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով: (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862 -তে কল করুন। (Bengali-Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862 . (Catalan)

Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu. (Chamorro)

ᏱᎩᏧᎾᏕᎶᏆᏍᏗᏱᎩᏳᎪᏛᎩᎸᎢᏳᎾᏛᏁᎲᎢᏳᎾᏝᎢᏍᏗᏉᏕᎲ ᏱᏣᎢ (GW) ᎤᏓᎳᏫᏎᏓ 1-888-982-3862 ᎤᏛᎢ ᏣᎠᏍᏓᏩᏗᎯᎸᎯᏳᎵᏍᏔᏅ. (Cherokee)

(Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862 . (Choctaw)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862 . (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862 . Kāki ʻole ʻia kēia kōkua nei. (Hawaiian)

(Hindi) हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862 . (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo. (Ilocano)

Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya. (Bahasa Indonesia)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862 . (Italian)

日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。(Japanese)

လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိဉ်အင်္ဂါ ကျိဉ် ကိး 1-888-982-3862 လၢတအိဉ်ဒီးတၢ်လၢာ်ဘျဉ်လၢာ်စုၤဘဉ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인1-888-982-3862 번으로 전화해 주십시오. (Korean)

Bɛ̀ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-888-982-3862 (Kru-Bassa)

بۆ وەرگرتنی ڕێنوێنی پێوەندیدار بە زمان بە زمان بە ژمارەی 1-888-982-3862 بە خۆڕایی پەیوەندی بکەن. (hsidruK)

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

तील भाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावर कोणत्याही खर्चाशिवाय कॉल करा. (Marathi)

Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān. (Marshallese)

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais. (Micronesian-Pohnpeian).

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् । (Nepali)

Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt. (Norwegian)

Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862 (Polish)

Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente. (Portuguese)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-982-3862 (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862 . (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi. (Samoan)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862 . (Serbo-Croatian)

Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862 . Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo. (Swahili)

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భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi. (Tongan)

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk. (Trukese-Chuukese)

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862 . (Turkish)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862 . (Ukrainian)

اُردو میں لسانی معاونت کے لیے 1-888-982-3862 پر مفت کال کریں۔ (udrU)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862 . (Vietnamese)

פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל. (Yiddish)

Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá. (Yoruba)

Health Maintenance Organization (HMO)
Evidence of Coverage

Prepared exclusively for

Contract holder:	**LIGHTING RESOURCES, INC.**
Contract holder number:	**0801556**
HMO agreement effective date:	**January 01, 2019**
Product Name:	**Aetna Value Network HMO**

Underwritten by AETNA HEALTH OF CALIFORNIA INC. in the State of CALIFORNIA

Welcome

Thank you for choosing **Aetna**.

This is your Evidence of Coverage, or EOC for short. It is one of three documents that together describe the benefits covered by your Aetna plan.

This EOC will tell you about your **covered benefits** – what they are and how you get them. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the group agreement between Aetna Health of California Inc. ("**Aetna**") and your contract holder. Ask your employer if you have any questions about the group agreement.

Oh, and each of these documents may have amendments or riders attached to them. They change or add to the documents they're part of.

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

Some **hospitals** and other **providers** do not provide one or more of the following services that may be covered under your plan that includes:

- Family planning
- Contraceptive services, including emergency contraception
- Sterilization, including tubal ligation at the time of labor and delivery
- Infertility treatments
- Abortion

Call your prospective **provider** or refer to *Let's get started! – How to contact us for help* section, if you have any questions.

Table of contents

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works. But for all the details – this is very important – you need to read this entire certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Aetna**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical medical language that is familiar to medical **providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered

Your HMO benefit plan:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
- Generally will pay only when you get care from **providers** in our **network** of doctors, **hospitals**, and other **providers**.

1. **Eligible health services**

   Doctor and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you want. Sometimes it doesn't cover health care services your doctor will want you to have.

   So what are **eligible health services**? They are health care services that meet these three requirements:

   - They are listed in the *Eligible health services under your plan* section.
   - They are not carved out in the *What your plan doesn't cover – some eligible health service exceptions* section. (We refer to this section as the "exceptions" section.)

- They are not beyond any limits in the schedule of benefits.

2. **Providers**

Aetna's network of doctors, **hospitals** and other health care **providers** are there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider directory**. Just log into your secure member website at www.aetna.com.

You choose a **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other **providers** when you need specialized care. Your plan often will pay a bigger share for **eligible health services** that you get through your **PCP**, so choose a **PCP** as soon as you can.

For more information about the **network** and the role of your **PCP**, see the *Who provides the care* section.

3. **Service area**

Your plan generally pays for **eligible health services** only within a specific geographic area, called a **service area**. There are some exceptions, such as for **emergency services** and urgent care. See the *Who provides the care* section.

4. **Paying for eligible health services– the general requirements**

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**, and
- You get your care from:
  - Your **PCP**, or
  - Another **network provider** after you get a **referra**l from your **PCP**, and
- Your **provider precertifies** the **eligible health service** when required.

You will find details on **medical necessity, referral** and **precertification** requirements in the *Medical necessity, referral and precertification requirements* section. You will find the requirement to use a **network provider** and any exceptions in the *Who provides the care* section.

5. **Paying for eligible health services– sharing the expense**

Generally your plan and you will share the expense of your eligible health services when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

6. **Disagreements**

We know that people sometimes see things differently.

The plan tells you how we will work through our differences. And if we still disagree, an

independent group of experts called an “external review organization” or ERO for short, will make the final decision for us.

For more information see the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your questions. You can contact us by logging onto your secure member website at www.aetna.com.

Register for Aetna's member website, our secure Internet access to reliable health information, tools and resources. Your member website online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can also contact us by:

- Calling **Aetna** Member Services at the toll-free number on your ID card
- Writing us at 1385 East Shaw Ave, Fresno, CA 93710

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this plan. Show your ID card each time you get health care from a **provider** to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage.

We will mail you your ID card. If you haven’t received it before you need **eligible health services**, or if you’ve lost it, you can print a temporary ID card. Just log into your secure member website at www.aetna.com.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

Your employer decides and tells us who is eligible for health care coverage.

When you can join the plan

- As an employee you can enroll yourself and your dependents if you live or work in the **service area**:
- At the end of any waiting period your employer requires
- Once each **calendar year** during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself and your dependents when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. (They are referred to in this EOC as your "dependents".)

- Your spouse

- Your domestic partner
  - You and your domestic partner will need to complete and sign a Declaration of Domestic Partnership with the California Secretary of State. Contact your **employer** for the form. To be eligible for coverage, a domestic partner must meet the following criteria:
    - He or she is your sole domestic partner and intend to remain so indefinitely
    - He or she is not married or legally separated from anyone else
    - He or she is not registered as a member of another domestic partnership within the past 6 months
    - He or she is of the age of consent in your state of residence
    - He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
    - He or she has cohabitated and resided with you in the same residence for the past 6 months and intends to cohabitate and reside with you indefinitely
    - He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses
    - He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage

- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
  - Common ownership of a motor vehicle
  - Driver's license with a common address
  - Proof of joint bank accounts or credit accounts
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits or primary beneficiary designation under your will
  - Assignment of a durable property power of attorney or health care power of attorney.

- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include:
    - Your biological children
    - Your stepchildren
    - Your legally adopted children
    - Your foster children, including any children placed with you for adoption
    - Any children you are responsible for under a qualified medical support order or court-order (without regard to whether or not the child resides with you and whether or not the child resides inside the **service area**)
    - Your grandchildren in your court-ordered custody
    - A grandchild when his/her parent is already covered as a dependent under this plan
    - Any other child with whom you have a parent-child relationship

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 60 days after the date of your marriage.
    - Ask your employer when benefits for your spouse will begin. It will be:
      - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
      - Within 60 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - We must receive your completed enrollment information not more than 60 days after the date you file a Declaration of Domestic Partnership, or not later than 60 days after you provide documentation required by your employer.
  - Ask your employer when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child - Your newborn child is covered on your health plan for the first 60 days after birth.

- To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
- You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
- If you miss this deadline, your newborn will not have health benefits after the first 60 days.

- An adopted child - A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 60 days after the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption.
  - If you miss this deadline, your adopted child will not have health benefits after the first 60 days.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 60 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask your employer when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another group health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
  - You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.
- When a court orders you to cover a current spouse or a minor child on your health plan.

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage will be in effect the first day of the month following receipt of your completed enrollment application.

Medical necessity, referral and precertification requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services.** See the *Eligible health services under your plan* and *exceptions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible health services** only if the general requirements are met. They are:

- The **eligible health service** is **medically necessary**, and
- You get your care from:
  - Your **PCP**, or
  - Another **network provider** after you get a **referra**l from your **PCP**.
- Your **provider precertifies** the **eligible health service** when required.

This section addresses the **medical necessity, referral** and **precertification** requirements. You will find the requirement to use a **network provider** and any exceptions in the *Who provides the care* section.

Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**." That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

Referrals

You need a **referral** from your **physician**, **PCP** for most **eligible health services**. If you do not have a **referral** when required, we won't pay the **provider**. You will have to pay for services if your **physician, PCP** fails to ask us for the referral. You do not need a referral to see a **network** obstetrician (OB), gynecologist (GYN) or OB/GYN. Refer to the *What the plan pays and what you pay* section.

Standing referral

When you require a specialized medical or mental health care over a prolonged period of time, we will issue you a standing **referral** to a **specialist**.

If we determine that your care should be coordinated by your **specialist**, we will:

- Authorize a standing **referral** for up to 12 months
- Make this decision within 3 business days of receiving the necessary information

Second opinion

You can also request a second opinion for a surgery or course of treatment recommended by your **PCP** or **provider**. You will need to:

- Go to a **provider** in your **PCP**'s affiliated medical group to obtain a second opinion for care by your **PCP**
- Go to a **network provider** to obtain a second opinion for care by a **specialist**
- Obtain the necessary **precertification** when required

- If there is no such **specialist** in our **network**, we will refer you to an **out-of-network provider**

You should contact your **PCP** to request a **referral** for a second opinion.

If your request needs to be expedited because of your health, we will respond to your request for a second opinion within 72 hours. For more information regarding second opinions, including our timelines to respond, contact Member Services at the toll-free number on your ID card.

Precertification

You need pre-approval from us for some **eligible health services**. Pre-approval is also called **precertification**.

Your **physician** or **PCP** is responsible for obtaining any necessary **precertification** before you get the care. If your **physician** or **PCP** doesn't get a required **precertification**, we won't pay the **provider** who gives you the care. You won't have to pay either if your **physician** or **PCP** fails to ask us for **precertification**. If your **physician** or **PCP** requests **precertification** and we refuse it, you can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important exceptions – when you pay all* section.

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital** stays. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- **Physician** care generally is covered but **physician** care for **cosmetic** surgery is never covered. This is an exception (exclusion).
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about these exceptions in the *exceptions* section, and about the limitations in the schedule of benefits.

We've grouped the health care services below to make it easier for you to find what you're looking for.

1. Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

Important notes:

1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

   These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the **calendar year**, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender-Specific *Preventive Care* benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your secure member website at www. aetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine physical exams

Eligible health services include office visits to your **physician**, **PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once every three years
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup

Preventive care immunizations

Eligible health services include immunizations provided by your **physician**, **PCP** for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician**, **PCP** obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

Preventive screening and counseling services

Eligible health services include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will

cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

- **Use of tobacco products**
  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**
  Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include the counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies

- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a network OB, GYN or OB/GYN without a **referral**.

Prenatal care

Eligible health services include your routine prenatal physical exams as preventive care, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

Eligible health services also include participation in the California Prenatal Screening Program. The State Department of Health Services administers this program.

You can get this care at your **physician's**, **PCP's**, OB's, GYN's, or OB/GYN's office.

Important note:
You should review the benefit under *Eligible health services under your plan- Maternity and related newborn care* and the *exception* sections of this EOC for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

Eligible health services include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of:

- An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every three years, or
- A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pump supplies and accessories
Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose. Including the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services
Eligible health services include education, counseling services and management of side effects provided by a **physician**, **PCP**, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices
Eligible health services include contraceptive devices (including any follow-up services, management of side effects and device insertion and removal) when they are provided by a **physician** during an office visit.

Voluntary sterilization
Eligible health services include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:
See the following sections for more information:
- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient **prescription drugs***
- *Treatment of basic **infertility***

2. Physicians and other health professionals

Physician services

Eligible health services include services by your **physician** to treat an **illness** or **injury**. You can get those services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine**

Important note:
Your plan covers **telemedicine** only when you get your telephone or internet-based consult through an authorized internet service vendor who conducts **telemedicine** consultations that has contracted with **Aetna** to offer these services. DocFind® tells you who those are. **Telemedicine** is not the same as an office visit and may have different cost sharing. See the schedule of benefits for specific plan details.

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your **surgery**
- Your surgeon who you visit before and after the **surgery**
- Another surgeon who you go to for a second opinion before the **surgery**

3. Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care.

The types of **hospital** care services that are eligible for coverage include:

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital**
- Operating and recovery rooms
- Intensive or special care units of a **hospital**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital,**

Anesthesia and hospital charges for dental care

Eligible health services include anesthesia for dental care only if you:

- Have a disability or condition that requires a dental procedure be done in a **hospital** or outpatient surgery center
- Are developmentally disabled
- Are in poor health and have a medical need for general anesthesia
- Are under 7 years old

Alternatives to hospital stays

Outpatient surgery and physician surgical services

Eligible health services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery center** or a **hospital's** outpatient department.

Important note:
Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician, PCP** services and not for a separate fee for facilities.

Home health care

Eligible health services include home health care services provided by a **home health agency** in the home, but only when all of the following criteria are met:

- You are homebound.
- Your **physician** orders them.
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a **physician** or social worker.

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the *Short-term rehabilitation services and Habilitation therapy services* sections and the schedule of benefits.

Home health care services do not include **custodial care**.

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care program**.

The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Bereavement counseling
- Respite care

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling

Skilled nursing facility

Eligible health services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies that are provided during your **stay** in a **skilled nursing facility**

For your **stay** in a **skilled nursing facility** to be eligible for coverage, the following conditions must be met:

- The **skilled nursing facility** admission will take the place of:
  - An admission to a **hospital** or sub-acute facility.
  - A continued **stay** in a **hospital** or sub-acute facility.
- There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time.
- The **illness** or **injury** is severe enough to require constant or frequent skilled nursing care on a 24-hour basis.

4. Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**.

As always, you can get emergency care from **network providers**. However, you can also get emergency care from **out-of-network providers**.

Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when **Aetna** and the attending **physician** determine that you are medically able to travel or to be transported to a **network provider** if you need more care.

You are covered for follow-up care only when your **physician**, **PCP** provides or coordinates it.

In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and **ambulance** assistance. If possible, call your **physician**, **PCP** but only if a delay will not harm your health.

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits and the *exception- Emergency services and urgent care* section for specific plan details.

In case of an urgent condition

Urgent condition within the service area

If you need care for an **urgent condition** while within the **service area**, you should first seek care through your **physician**, **PCP.** If your **physician**, **PCP** is not reasonably available to provide services, you may access urgent care from a network **urgent care facility** within the **service area**.

Urgent condition outside the service area
You are covered for urgent care obtained from a facility outside of the **service area** if you are temporarily absent from the **service area** and getting the health care service cannot be delayed until you return to the **service area**.

Non-urgent care
If you go to an **urgent care facility** for what is not an **urgent condition,** the plan may not cover your expenses. See the *exception –Emergency services and urgent care* section and the schedule of benefits for specific plan details.

5. Specific conditions

Gender reassignment

Eligible health services include, but are not limited to, the following services:

- Hormone therapy
- Hysterectomy
- Mastectomy
- Vocal training

These services will not be denied if you enrolled as a member of the opposite sex or are in the process of a gender transition.

Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies:
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Diabetic needles and syringes
  - Injection aids for the blind
  - Diabetic test agents
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
- Equipment:
  - External insulin pumps
  - Blood glucose monitors without special features, unless required due to blindness
- Training:
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

This coverage is for the treatment of insulin (type I), non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Family planning services – other

Eligible health services include certain family planning services provided by your **physician** such as:

- Voluntary sterilization for males

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. After your child is born, **eligible health services** include:

- 48 hours of inpatient care in a network **hospital** after a vaginal delivery
- 96 hours of inpatient care in a network **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 2 post-delivery home visits by a health care **provider**.

Coverage also includes the services and supplies needed for circumcision by a **provider**.

Mental health treatment

Eligible health services include the treatment of **mental disorders**, including that are defined as severe mental illnesses and/or serious emotional disturbances of a child, and that are provided by a **hospital**, **psychiatric hospital**, **residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation).
  - All other outpatient mental health treatment, including:
    - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Electro-convulsive therapy (ECT)
    - Monitoring of and the administration of injectable medications
    - Behavioral health treatment for pervasive developmental disorder or autism
    - Skilled behavioral health services provided in the home
    - Psychological and neuropsychological testing done by a **physician** or **behavioral health provider** such as **psychiatrist**, psychologist, social worker, or licensed professional counselor
    - Transcranial Magnetic Stimulation (TMS)

Severe mental illness means the following:

- Anorexia/bulimia nervosa
- Bipolar disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Panic disorder
- Pervasive developmental disorder (including autism)
- Psychotic disorders/delusional disorder
- Schizo-affective disorder

- Schizophrenia

A child suffering from serious emotional disturbances means a child who:

- Has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (other than a primary substance use disorder or developmental disorder)
- Has inappropriate behavior for the child's age according to expected developmental norms
- Meets the criteria in California's Welfare and Institutions Code

Behavioral health treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore the functioning of any individual with pervasive developmental disorder or autism. Behavioral health treatment must:

- Be prescribed by a **physician** or psychologist
- Be provided under a treatment plan prescribed by a qualified autism service provider
- Be administered by qualified autism service providers, qualified autism service professionals or qualified autism service paraprofessionals

The treatment plan must:

- Have measurable goals
- Be reviewed at least every six months
- Change whenever appropriate
- Describe the conditions that need to be treated
- Include the service type, number of hours, and parent participation needed
- End when treatment goals are met or no longer appropriate

A treatment plan is not used for **custodial care** or educational services. We can ask for a copy of the treatment plan.

The following services require **precertification**:

- Behavioral health treatment for pervasive developmental disorder or autism
- Inpatient admissions
- **Intensive outpatient programs**
- Neuropsychological testing
- **Partial hospitalization treatment**
- Psychological testing
- **Residential treatment facility** admissions
- Skilled behavioral health services provided in the home

Important note:
You may still be eligible for services under state law, including the Lanterman Developmental Disabilities Services Act, California Early Intervention Services Act, and services delivered as part of an individualized education program for individuals with exceptional needs.

Important note:
Your plan covers **telemedicine** only when you get your telephone or internet-based consult through an authorized internet service vendor who conducts **telemedicine** consultations that has contracted with Aetna to offer these services. DocFind® tells you who those are.

Substance related disorders treatment

Eligible health services include the treatment of **substance abuse** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate** and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility.** Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

  As used here, "medical complications" include, but are not limited to, **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (including **telemedicine** consultation).
  - All other outpatient substance related disorders treatment, including:
    - Outpatient **detoxification**
    - Ambulatory **detoxification**, which is an outpatient service that monitors withdrawal from alcohol or other **substance abuse**, and may include administration of medications
    - **Partial hospitalization treatment** (also known as day treatment) provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - Monitoring of and the administration of injectable medications
    - Treatment of withdrawal symptoms
    - Skilled behavioral health services provided in the home

The following services require **precertification**:

- Inpatient admissions
- **Intensive outpatient programs**
- Outpatient **detoxification**
- **Partial hospitalization treatment**
- **Residential treatment facility** admissions
- Skilled behavioral health services provided in the home

Important note:
Your plan covers **telemedicine** only when you get your telephone or internet-based consult through an authorized internet service vendor who conducts **telemedicine** consultations that has contracted with

Aetna to offer these services. DocFind® tells you who those are.

Reconstructive surgery and supplies

Eligible health services include reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of the mastectomy, including lymphedema. Your **physician** will determine how long you **stay** in the **hospital** following your mastectomy.
- Your **surgery** corrects or repairs abnormal structures of the body caused by:
    - Congenital defects
    - Developmental abnormalities
    - Trauma
    - Infection
    - Tumors
    - Disease
    - Cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate
- Your **surgery** will improve function or create a normal appearance.
- There are no other more appropriate surgical procedures
- Your **surgery** offers more than a minimal improvement in your appearance.

Transplant services

Eligible health services include organ transplant services provided by a **physician** and **hospital** only when we **precertify** them.

Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Network of transplant specialist facilities

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need.

The National Medical Excellence Program® will coordinate all solid organ and bone marrow transplants, and other specialized care you need.

Treatment of basic infertility

Eligible health services include basic **infertility** care, including seeing a **network provider** to diagnose the underlying medical cause of **infertility** and any **surgery** needed to treat the underlying medical cause of **infertility**.

6. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a **provider**, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (*MRA*)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds $500.

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Chemotherapy

Eligible health services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician** in his/her office
- A home care **provider** in your home

You can access the list of preferred infusion locations by contacting Member Services by logging onto your secure member website at www.aetna.com or calling the number on the back of your ID card.

Infusion therapy is the parenteral (i.e. intravenous) administration of prescribed medications or solutions.

Certain infused medications may be covered under the outpatient **prescription drug** rider. You can access the list of **specialty prescription drugs** by contacting Member Services or by logging onto your secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the outpatient **prescription drug** rider or this EOC.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Outpatient radiation therapy

Eligible health services include the following radiology services provided by a **health professional**:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility** or **physician's** office, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services as part your inpatient **hospital stay** if it is part of a treatment plan ordered by your **physician**.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a **hospital, skilled nursing** facility, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living. **Eligible health services** include short-term rehabilitation services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Short-term rehabilitation services have to follow a specific treatment plan, ordered by your **physician.**

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure.**
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure**, or
  - Relearn skills so you can significantly improve your ability to perform activities of daily living on your own.

  - Speech therapy without regard to whether there is a physical cause.

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Spinal manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem.

Your **provider** must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

Habilitation therapy services

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age)
Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, if it is expected to develop any impaired function
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
  - Develop any impaired function, or
  - Relearn skills so you can significantly develop your ability to perform activities of daily living on your own.
- Speech therapy is covered without regard to whether there is a physical cause.

7. Other services

Acupuncture

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered **surgical procedure** and
- To alleviate chronic pain or to treat:
  - Postoperative and chemotherapy-induced nausea and vomiting
  - Nausea of pregnancy
  - Postoperative dental pain
  - Temporomandibular disorders (TMD)
  - Migraine headache
  - Pain from osteoarthritis of the knee or hip (adjunctive therapy)

Ambulance service

Eligible health services include transport by professional ground **ambulance** services:

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

Your plan also covers transportation to a **hospital** by professional air or water **ambulance** when:

- Professional ground **ambulance** transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one **hospital** to another and
  - The first **hospital** cannot provide the **emergency medical services** you need, and
  - The two conditions above are met.

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or terminal illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.

- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred to you by a **provider** in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
  - For those approved by the Departments of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
    - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

Your plan only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that your plan does not. We list examples of those in the *exceptions* section.

Nutritional supplements

Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of phenylketonuria or any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Obesity (bariatric) surgery

Eligible health services include obesity surgery, which is also known as "weight loss surgery." Obesity surgery is a type of procedure performed on people who are **morbidly obese**, for the purpose of losing weight.

Obesity is typically diagnosed based on your **body mass index (BMI)**. To determine whether you qualify for obesity surgery, your doctor will consider your **BMI** and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a **BMI** less than 35.

Your doctor will request approval from us in advance of your obesity surgery. We will cover charges made by a **network provider** for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription drug** benefits included under the Outpatient **prescription drugs** section

Health care services include one bariatric **surgical procedure.** However, **eligible health services** also include a multi-stage procedure when planned and approved by us. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may go to any of our **network** facilities that perform obesity surgeries.

Orthotic devices

Eligible health services include mechanical supportive devices ordered by your **physician** for the treatment of weak or muscle deficient feet.

Eligible health services also include special footwear if you suffer from a foot disfigurement caused by:

- Cerebral palsy
- Arthritis
- Polio
- Spinabifida
- Diabetes
- Accidental or developmental disability.

Osteoporosis

Eligible health services include the diagnosis, treatment and management of osteoporosis by a **physician**. The services include Food and Drug Administration approved technologies, including bone mass measurement.

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers. But we cover it only if we approve the device in advance.

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects.

Coverage includes:

- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device

Spinal manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem, but only if your **provider** establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

Vision care

Pediatric vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Adult vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

What your plan doesn't cover – some eligible health service exceptions

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. And we told you there, that some of those health care services and supplies have exceptions (exclusions). For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exception (exclusion).

In this section we tell you about the exceptions. We've grouped them to make it easier for you to find what you want.

- Under "General exceptions" we've explained what general services and supplies are not covered under the entire plan.
- Below the general exceptions, in "Exceptions under specific types of care," we've explained what services and supplies are exceptions under specific types of care or conditions.

Please look under both categories to make sure you understand what exceptions may apply in your situation.

And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exceptions

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis

For autologous blood donations, only administration and processing expenses are covered.

Cosmetic services and plastic surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons.

Counseling

- Religious, career, or financial counseling.

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed.
- Administering oral medications.
- Care of a stable tracheostomy (including intermittent suctioning).
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
- Care of a bladder catheter (including emptying/changing containers and clamping tubing).
- Watching or protecting you.
- Respite care, adult (or child) day care, or convalescent care.
- Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care.
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods.
- Any other services that a person without medical or paramedical training could be trained to perform.
- Any service that can be performed by a person without any medical or paramedical training.

Dental care

- Dental services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, job training and job hardening programs.
- Services eligible under the Individuals with Disabilities in Education Act (IDEA).

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a law requires it.

- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under *Clinical trial therapies (experimental or investigational)* or covered under *Clinical trials (routine patient costs)*. See the *Eligible health services under your plan – Other services* section.

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Foot care

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes, or fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies

Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth except as needed for gender reassignment. See the *Eligible health services under your plan-Gender reassignment* section

Hearing aids and exams

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans

- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Outpatient prescription or non-**prescription drugs** and medicines

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer.
- Drugs that are included on the list of **specialty prescription drug** as covered under your outpatient **prescription drug** plan.

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party.

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member.

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, outpatient **prescription drugs** or supplies received outside of the United States. They are not covered even if they are covered in the United States under this EOC.

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery**, **prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing your strength, physical condition, endurance, or physical performance.

Telemedicine

- Any services that are given by **providers** that are not contracted with **Aetna** as **telemedicine providers**. Any services that are not provided during an internet-based

consult or via telephone.

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Vision care

- Vision care services and supplies, including:
  - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and
  - Laser in-situ keratomileusis (LASIK), including related procedures designed to surgically correct refractive errors

Wilderness Treatment Programs

- Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution).

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "non-occupational" regardless of cause.
- The **eligible health services** under this plan are not designed to duplicate any benefit to which you are entitled under workers' compensation law. All sums payable for workers' compensation

services provided under this plan shall be payable to, and retained by us. You shall complete and submit to us such consents, releases, assignments and other documents reasonably requested by us in order to obtain or assure reimbursement under the worker's compensation law.

Additional exceptions for specific types of care

1. Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care
- Services not given by a **physician** or under his or her direction
- Psychiatric, psychological, personality or emotional testing or exams

2. Physicians and other health professionals

There are no additional exceptions specific to **physicians** and other **health professionals**.

3. Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital (hospital stays** are covered in the *Eligible health services under your plan – **Hospital** and other facility care* section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Home health care

- Services for infusion therapy
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation

- Maintenance of the house

Private duty nursing (See home health care in the ***Eligible health services*** *under your plan* section regarding coverage of nursing services).

4. Emergency services and urgent care

- **Non-emergency care** in a **hospital** emergency room facility
- Non-urgent care in an **urgent care facility** (at a non-hospital freestanding facility)

5. Specific conditions

Artificial organs

- Any device that would perform the function of a body organ.

Family planning services - other

- Voluntary sterilization for males
- Voluntary termination of pregnancy
- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility

Maternity and related prenatal care

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)):
  - Dementias and amnesias without behavioral disturbances
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders
  - Specific disorders of sleep
  - Antisocial or dissocial personality disorder
  - Pathological gambling, kleptomania, pyromania
  - Specific delays in development (learning disorders, academic underachievement)
  - Intellectual disability
  - Wilderness Treatment Program or any such related or similar program
  - School and/or education service.

Substance related disorders treatment

- Except as provided in the *Eligible health services under your plan – Substance related disorders treatment* section alcoholism or drug abuse rehabilitation treatment on an inpatient or outpatient basis

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing **illness**
- Harvesting and/or storage of bone marrow, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**

Treatment of infertility

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation of eggs, embryos, or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
  - Obtaining sperm for ART services**.**
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures.
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).

6. Specific therapies and tests

Acupuncture and acupuncture therapy

Outpatient infusion therapy

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer.
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan.
- Enteral nutrition
- Blood transfusions and blood products, but not the administration of the blood or blood products
- Dialysis

Short-term rehabilitation services

Outpatient cognitive rehabilitation, physical, and occupational therapy

- Except for physical therapy or occupational therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Down syndrome
  - Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.
- Services for the treatment of delays in development unless as a result of a gross anatomical defect present at birth.

Habilitation therapy services

Physical and occupational therapy

- Except for physical therapy or occupational therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. An example of a non-covered diagnosis that is considered both developmental and/or chronic in nature is:
  - Down syndrome
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.
- Services for the treatment of delays in development unless as a result of a gross anatomical defect present at birth.

7. Other services

Ambulance services

- Fixed wing air ambulance from an **out-of-network provider**

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (**experimental or investigational**), except as described in the *Eligible health services under your plan - Clinical trial therapies (**experimental or investigational**)* section.

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

Durable medical equipment (DME)

Examples of these are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Message devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Nutritional supplements

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Other services* section

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Spinal manipulation

- Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body.
- Other physical treatment of any condition caused by or related to neuromusculoskeletal disorders of the spine, including manipulation of the spine.

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about **network providers**.

Network providers

We have contracted with **providers** in the **service area** to provide **eligible health services** to you. These **providers** make up the **network** for your plan. For you to receive the **network** level of benefits, you must use **network providers** for **eligible health services**. There are three exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the ***Eligible health services*** *under your plan* section.
- Urgent care – refer to the description of emergency services and urgent care in the ***Eligible health services*** *under your plan* section.
- **Network provider not reasonably available** – You can get **eligible health services** under your plan that are provided by an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must request access to the **out-of-network provider** in advance and we must agree. Contact Member Services at the toll-free number on your ID card for assistance.

You may select a **network provider** from the **directory** through your secure member website at www.aetna.com. You can search our online **directory**, DocFind®, for names and locations of **providers**.

You will not have to submit claims for treatment received from **network providers**. Your **network provider** will take care of that for you. And we will directly pay the **network provider** for what the plan owes.

Your PCP

For you to receive the **network** level of benefits **eligible health services** must be accessed through your **PCP's** office. They will provide you with primary care.

A **PCP** can be any of the following **providers** available under your plan:

- General practitioner
- Family physician
- Internist
- Pediatrician
- OB, GYN, and OB/GYN

How do you choose your PCP?

You can choose a **PCP** from the list of **PCPs** in our **directory**. See the *Who provides the care, **Network providers*** section.

Each covered family member is required to select their own **PCP.** You may each select your own **PCP**. You must select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What will your PCP do for you?
Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Your **PCP** can also:

- Order lab tests and radiological services.
- Prescribe medicine or therapy.
- Arrange a **hospital stay** or a **stay** in another facility**.**

Your **PCP** may be affiliated with other medical groups (i.e. integrated delivery systems, independent practice associations (IPAs) and physician-hospital organizations). If you select a **PCP** with these affiliations, you will probably be referred to **specialists** and **hospitals** within that medical group.

Your **PCP** will give you a written or electronic **referral** to see other **network providers**.

How do I change my PCP?
You may change your **PCP** at any time. You can call us at the toll-free number on your ID card or log on to your secure member website at www. aetna.com to make a change.

What happens if I do not select a PCP?
Because having a **PCP** is so important, we may choose one for you. You will get an ID card in the mail. We will tell you the name, address and telephone number of your **PCP**.

Your **eligible health services** will be limited to care provided by direct access **network providers**, **emergency services** and urgent care services.

How is my PCP paid?
Your **PCP** and other **providers** may be paid in any of the following ways, depending on their contract with us:

- A fixed price per service
- A fixed price per day
- A fee for each service set by a fee schedule
- A fixed monthly amount per member

Providers who contract with us have no requirement to comply with:

- Specified numbers
- Targeted averages
- Maximum duration for patient visits

We design our compensation arrangements to encourage our **providers** to provide the most appropriate care and to discourage unnecessary and potentially detrimental care.

When **providers** are paid a fixed monthly amount per member, we incorporate specific “quality factors” into the compensation process. These quality factors include:

- Appropriate diagnostic testing
- Specialty and **hospital** utilization
- Member satisfaction survey results

- Thoroughness of medical chart documentation
- Clinical care measures for diabetes, asthma and other conditions
- Number of scheduled office hours
- Range of office procedures offered
- Around the clock coverage
- Participation in continuing education programs

We encourage you to ask your **PCP** and other **providers** how they are paid, including if their contracts include any financial incentives.

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network.
- You are already a member of **Aetna** and your **provider** stops being in our network.

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

	If you are a new enrollee	When your provider stops participation with Aetna
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by calling the toll free number on your ID card.	You or your provider should call Aetna for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the provider terminated their participation with Aetna.

If you are pregnant, the transitional period will include the time through postpartum care directly related to the delivery.

If you are receiving mental health treatment, care will continue during a transitional period of one year.

We will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

What the plan pays and what you pay

Who pays for your **eligible health services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **copayments/coinsurance**
- Your **maximum out-of-pocket limit**

We also remind you that sometimes you will be responsible for paying the entire bill: for example, if you get care that is not an **eligible health service**.

The general rule

When you get **eligible health services**:

- You pay for the entire expense up to any **deductible** limit.

  And then

- The plan and you share the expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/coinsurance**.

  And then

- The plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

Important exception – when your plan pays all

Your plan pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

- When your plan requires **precertification**, your physician requested it, we refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity, referral and precertification requirements* section.

- Usually, when you get an **eligible health service** from someone who is not a **network provider**. See the *Who provides the care* section.

In all these cases, the **provider** may require you to pay the entire charge. And any amount you pay will not count towards your **deductible** or towards your **maximum out-of-pocket limit**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage

- Charges, expenses, or cost is in excess of the **negotiated charge**

Where your schedule of benefits fits in

How your copayment/coinsurance works

Your **copayment/coinsurance** is the amount you pay for **eligible health services**. Your schedule of benefits shows you which **copayments/coinsurance** you need to pay for specific **eligible health services**.

You will pay the **PCP copayment/coinsurance** when you select a **PCP** and get **eligible health services** from them. You will pay the **specialist copayment/coinsurance** when you get **eligible health services** from a network **PCP** that is not your **PCP**. If you did not select a **PCP** you will pay the **specialist copayment/coinsurance** for **eligible health services** from any network **PCP** or network **specialist**.

How your maximum out-of-pocket limit works

You will pay your **deductible** and **copayments/coinsurance** up to the **maximum out-of-pocket limit** for your plan. Your schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered benefits** for the remainder of that **calendar year**.

Important note:
See the schedule of benefits for any **deductibles, copayments/coinsurance, maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible health services**.

When a claim comes in, we decide and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

The California Department of Managed Health Care is responsible for regulating health care service plans. When you disagree with us, you should first follow our claims and appeals process before contacting the Department. Following our processes does not prohibit any potential legal rights or remedies that may be available to you.

You can call the Department for help with a complaint or appeal involving:

- An emergency
- One that has not been satisfactorily resolved us
- One that has remained unsolved for more than 30 days

You may also be eligible for an Independent Medical Review (IMR) as explained below. The IMR process will provide an impartial review of medical decisions made by us.

The Department has a toll-free telephone number 1-888-HMO-2219 and a TDD line 1-877-688-9891 for the hearing and speech impaired. The Department's Internet Web site (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions.

Types of claims and communicating our claim decisions

Your **network provider** will send us a claim on your behalf. And we will review that claim for payment to the **provider**.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

An urgent claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them.

Post-service claim

A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension

A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments/coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital.**

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (us)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

We pay many claims at the full rate negotiated with a **network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your coverage entirely.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A Complaint

You may not be happy about a **network provider** or an operational issue, and you may want to complain. You can call the toll-free number on your ID card, or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint**.** We will let you know if we need more information to make a decision.

An Appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling the toll-free number on your ID card.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, by calling the toll-free number on your ID card.
You need to include:

- Your name
- Your employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling the toll-free number on your ID card. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process

In most situations you must complete the two levels of appeal with us before you can take these other actions:

- Contact the California Department of Managed Health Care to request an investigation of a complaint or appeal. File a complaint or appeal with the California Department of Managed Health Care.
- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the independent medical review process.
- We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.

Independent medical review

Independent medical review is a review managed by the California Department of Managed Health Care.

You have a right to an independent medical review if:

- We decided the service or supply is not **medically necessary** or not appropriate (disputed health care service).
- We decided the service or supply is **experimental or investigational**.

If our claim decision is one for which you can seek independent medical review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will include the independent medical review application form. You should complete the form and send it (in the envelope provided) to the California Department of Managed Health Care. The Department will review your request and determine if you are eligible for independent medical review.

When we receive notice from the Department approving your request for an independent medical review, we will submit the documents required to the Department, you and your **provider**.

Your appeal will be submitted to the Independent Medical Review Organization (IMRO) for review by a medical specialist or a panel of medical specialists. Those specialists will determine whether or not the care is **medically necessary**. You will receive a copy of the independent medical review assessment.

The independent medical review will not cost you any money.

Independent medical review procedure for disputed health care services

You must:

- File an appeal regarding the disputed health care services
- Have participated in our appeals process for 30 days
- Received our final appeal decision

If your appeal involves an expedited complaint or appeal, you are not required to participate in our appeals process for more than three days.

Your **provider** must have recommended the services or you must have received urgent or emergency care that a **provider** deemed **medically necessary**. Or, you must have been seen by a **provider** for the diagnosis or treatment of the medical condition. Upon request, we will expedite access to a **network**

provider. You may request an independent medical review whether or not the **provider** recommends the service.

You may also request an independent medical review for services recommended or performed by an **out-of-network provider**. We have no liability to pay for the services of an **out-of-network provider** unless you have been referred according to the referral requirements. See the *Medical necessity, referral and precertification requirements* section for more details.

Independent medical review procedure for experimental and investigative treatment
You can request an independent medical review when:

- You have a life-threatening or seriously debilitating illness
- Your **physician** certifies that you have that condition and:
  - Standard therapies have not been effective in improving your condition
  - Standard therapies would not be medically appropriate
  - There is no more beneficial standard therapy covered by the plan than what your **physician** is proposing
  - Your **physician** has certified in writing that the proposed treatment is more beneficial to you than any other standard therapy
  - You or your **physician** has provided us with a written statement that certifies the requested treatment is more beneficial to you than any other standard therapy. You or your **physician** must base this statement on two forms of medical and scientific evidence.

The chart below shows a timetable view of the independent medical review timeline.

Type of treatment	When we notify you	When we send info to the DMHC	When the IMRO decides
Experimental and investigative	5 days	3 days after receiving notice they approved your request 24 hours for urgent request	30 days 3 days for urgent request
Disputed healthcare services	At the end of the appeals process	3 days after receiving notice they approved your request 24 hours for urgent request	30 days 3 days for urgent request

What happens after the IMRO makes their decision?
If the IMRO determines that the care requested is **medically necessary**, or does not qualify as **experimental** or **investigational**, we will cover the services which were the subject of the appeal.

There are two scenarios when you may be able to get a faster external review:
For initial adverse determinations
Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

For final adverse determinations

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Binding arbitration

When we say "interested parties" we mean:

- You
- Your heirs-at-law
- Your personal representative
- A **provider**
- Us
- Any agents, employees, or subcontractors of anyone listed above

If you cannot resolve your problem through the complaint processes described in the *When you disagree – claim decisions and appeals procedures* section you can ask for binding arbitration. Binding arbitration is the final step you can take to resolve your complaint with us.

When you became a member, you agreed to submit all unresolved complaints to binding arbitration, including complaints about medical malpractice. This means that you have agreed to give up your right to a trial by jury and other legal proceedings. Your request should be submitted within 60 days of receiving our final determination notice and/or any independent medical review decision.

Binding arbitration is a way to solve disputes, disagreements or problems without filing a formal lawsuit and:

- Is usually less expensive and takes less time than a lawsuit
- Can be requested by us or the interested parties

Agreement to binding arbitration

A request for binding arbitration results in the following:

- One or more people, called arbitrators, who are not connected with you or with us make the final decision on your case
- Together, you and **Aetna** choose and approve the arbitrators
- The arbitrators review the case and then write a decision, called an opinion

- Both you and **Aetna** must accept (be bound by) the decision of the arbitrators
- There will be no right to a jury trial
- Any medical malpractice claims against your **provider** will not include us
- Any punitive damages award must be:
  - Authorized
  - Recoverable under applicable law
  - Be based on clear evidence of our outrageous conduct
  - Be reasonable in relation to the actual damages
- You cannot participate in any class action suits related to your coverage

How to request binding arbitration
To start the arbitration process you should contact the American Arbitration Association (AAA), or other neutral dispute resolution organization that we agree upon. The AAA can be reached by calling or writing:

- Los Angeles Regional Office
  725 South Figueroa, Suite 400
  Los Angeles, CA 90017
  (213) 383-6516
- San Diego Regional Office
  402 W. Broadway, Suite 400
  San Diego, CA 92101
  (619) 239-3051
- San Francisco Regional Office
  One Sansome Street, Suite 1600
  San Francisco, CA 94104
  (415) 981-3901
- Customer service 1-800-778-7879

The AAA website is www.adr.org.

If the AAA declines the case or we do not agree on a different organization, then a neutral arbitrator shall be appointed upon petition to the court. You can decide where the arbitration is held.

Paying for binding arbitration
You and **Aetna** share equally the fees and expenses of the arbitrator. If you cannot pay your part of the arbitrator's fees and expenses, you may ask us to pay. For more information or an application for financial hardship, contact AAA or call the toll-free Member Services number on your member ID card.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms we use in this section. These terms will help you understand this *COB* section.

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic surgery** generally is not an allowable expense under this plan.

In this section when we talk about a "plan" through which you may have other coverage for health care expenses, we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist.
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or Dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.

Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: • **Online:** Log on to your secure member website at www.aetna.com. Follow the path to find a form. • **By phone:** Call the toll-free number on your ID card.	
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse's plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse's plan is primary.
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parent pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Child covered by: • Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination: See *Child of* content above.	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).

COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary **plan** that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.
Benefit reserve each family member has a separate benefit reserve for each **contract year**	The benefit reserve: • Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each year

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

When you are enrolled in Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

Who pays first?

If you are enrolled due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and your employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary **plan** and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is Primary	We calculate our benefit as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expense.

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

- **Online:** Log on to your secure member website at www.aetna.com.
- **By phone:** Call the toll-free number on your ID card.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid; or
- Any other plan that is responsible under these COB rules.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued.
- You voluntarily stop your coverage.
- The group agreement ends.
- You are no longer eligible for coverage, including when you move out of the **service area**.
- Your employment ends.
- You do not make any required contributions.
- We end your coverage.
- You become covered under another medical plan offered by your employer.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- You do not make the required contribution toward the cost of dependents' coverage.
- Your coverage ends for any of the reasons listed above (other than:
  - If you enroll under a group Medicare + Choice plan that we offer. However, dependent's coverage will end if your coverage ends under the Medicare + Choice plan

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends. You should provide your employer a completed and signed Declaration of Termination of Domestic Partnership.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end you and your dependents coverage?

We will give you 60 days advance written notice if we end your coverage because:

- You do not cooperate or give facts that we need to administer the *COB* provisions.

We may also end your coverage if:

- Within 30 days after receipt of a certified written notice if you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *A bit of this and that - Honest mistakes and intentional deception* section for more information on rescissions.
- Any statement made is considered a representation and not a warranty. We will only use a

statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

On the date your coverage ends, we will refund to your employer any prepayments for periods after the date your coverage ended.

We will not end your coverage because of your health status or health care needs. We also will not end your coverage because you filed an appeal. If you believe we ended your coverage because of these things, you may request a review by the Director of the California Department of Managed Health Care. See the *When you disagree – claim decisions and appeals procedures* section.

When will we send you a notice of your coverage ending?

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in "Why we would end your coverage").

Your coverage will end on the day before the first **premium** contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents at the end of the month following the date on which you no longer meet the eligibility requirements.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to employers of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Employer/Group health plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – employer or	Notify you and your	Within 90 days after active

Aetna	dependents of COBRA rights.	employee coverage begins
Notice of qualifying event – employer	Your active employment ends for reasons other than gross misconduct Your working hours are reduced You become entitled to benefits under Medicare You die You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – employer or Aetna	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA **– employer or Aetna**	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice **– employer or Aetna**	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period.	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify your employer if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify your employer if: • The Social Security Administration determines that you or a covered dependent	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends

	qualify for disability status	
Notice of qualified beneficiary's status change to non-disabled	Notify your employer if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify your employer if: • **You are electing COBRA**	**60 days from the qualifying event. You will lose your right to elect, if you do not:** • **Respond within the 60 days** • **And send back your application**

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?

You enroll by sending in an application and paying the **premium**. Your employer has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This

additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified your employer within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health plan that does not exclude coverage for pre-existing conditions or the preexisting conditions exclusion does not apply.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons

To request an extension of coverage**,** just call the toll-free Member Services number on your ID card.

How can you extend coverage if you are totally disabled when coverage ends?

Your coverage may be extended if you or your dependents are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension.

You are “totally disabled” if you cannot work at your own occupation or any other occupation for pay or profit.

Your dependent is “totally disabled” if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 36 months of coverage

How can you extend coverage when getting inpatient care when coverage ends?

Your coverage may be extended if you or your dependents are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren’t extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

- When you are discharged
- When you no longer need inpatient care
- When you become covered by another health benefits plan
- 36 months of coverage

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly (more than 50% of income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We will send you a notice at least 90 days before your child reaches the plan age limit. We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once every two years. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

How can you extend coverage for a child in college on medical leave?

You have the right to extend coverage for your dependent college student who takes a medically necessary leave of absence from school. The right to coverage will be extended until:

- The earlier of one year after the leave of absence begins, or
- The date coverage would otherwise end.

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness** or **injury.**
- Cause the dependent child to lose status as a full-time student under the plan, and
- Be certified by the treating doctor as medically necessary due to a serious **illness** or **injury.**

The doctor treating your child will be asked to keep us informed of any changes.

A bit of this and that

We gathered a number of provisions here. They talk about several different things, so we call this part "a bit of this and that."

Administrative provisions

How you and we will interpret this EOC

We prepared this EOC according to ERISA, and according to other federal laws and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this EOC when we administer your coverage, so long as we use reasonable discretion.

How we administer this plan

We apply policies and procedures we've develop to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the **HMO agreement**. This document may have amendments or riders too. Under certain circumstances, we or your employer or the law may change your plan. Only **Aetna** may waive a requirement of your plan. No other person – including your employer or **provider** – can do this.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or your employer any unearned **premium**.

Legal action

You cannot take any legal action against **Aetna** until 60 days after we receive written submission of claim.

Honest mistakes and intentional deception

Honest mistakes

You or your employer may make an honest mistake in your application for coverage. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to an **Aetna** appeal.
- You have the right to a third party review conducted by the California Department of Managed Health Care.

Some other money issues

Assignment of benefits

When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider** we may choose to pay you or to pay the **provider** directly. You do not have the right to assign your benefits or any rights under this plan to an **out-of-network provider**.

Financial sanctions exclusions

If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible health services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of overpayments

We sometimes pay too much for **eligible health services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **provider** – to return what we paid. If we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

When you are injured

If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money. We are entitled to that money, based on the reasonable cost of benefits we pay for your care. We have that right no matter who the money comes from – for example, the other driver, your employer or another insurance company.

To help us get paid back, you are doing four things now:

- You are agreeing to repay us from money you receive because of your **injury**.
- You are giving us a right to seek money in your name, from any person who causes you **injury** and from your own insurance. We can seek money only up to the amount we paid for your care.
- You are agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money for your **injury** or **illness**. You'll hold any money you receive until we are paid in full. And you'll give us the right to money you get, ahead of everyone else.
- You are agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

The amount of the money can be reduced if a judge, jury, or arbitrator decides you had some fault for the injury.

The amount of the money owed will not exceed one-third of the recovery, settlement, judgment or other source of compensation if you have an attorney or one-half of the recovery, settlement, judgment or other source of compensation if you did not have an attorney.

Sometimes your **provider** may also be entitled to that money. If your **provider** has been paid capitation, the lien will be limited to 80% of the usual and customary charge for the same service charged in the geographic region on a fee for service basis.

Your health information

We will protect your health information. We use and share it to help us process your **providers**' claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices, by calling the toll-free number on your ID card.

When you accept coverage under this plan, you agree to let your **providers** share your information with us. We need information about your physical and mental condition and care.

Glossary

Aetna
Aetna Health of California Inc., a California corporation holding a certificate of authority from the California Department of Managed Health Care as a health maintenance organization, operating according to Chapter 2.2 of Division 2 of the Health and Safety Code (commencing with Section 1340), commonly known as the Knox-Keene Health Care Service Plan Act of 1975.

Ambulance
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Behavioral health provider
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse** under the laws of the jurisdiction where the individual practices. Also includes qualified autism service providers, qualified autism service professionals and qualified autism service paraprofessionals

Body mass index
This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Brand-name prescription drug
A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Coinsurance
The specific percentage you have to pay for a health care service listed in the schedule of benefits.

Contract year
A period of 1 year beginning on the contract holder's **effective date of coverage**.

Copay, copayments
The specific dollar amount you have to pay for a health care service listed in the schedule of benefits.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:

1. They are **medically necessary.**
2. You received **precertification** and/or a **referral**, if required.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it is prescribed by a **physician** or given by trained medical personnel.

Deductible
The amount you pay for **eligible health services** per **contract year** before your plan starts to pay as listed in the schedule of benefits.

Detoxification
The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This could be done by metabolic or other means determined by a **physician**. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory
The list of **network providers** for your plan. The most up-to-date **directory** for your plan appears at www.aetna.com under the provider search label. When searching provider search, you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain **Aetna** plans.

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage
The date you and your dependents coverage begins under this EOC as noted in **Aetna's** records.

Eligible health services
The health care services and supplies listed in the *Eligible health services under your plan* section and not carved out or limited in the *exceptions* section or in the schedule of benefits**.**

Emergency admission
An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services.**

Emergency medical condition

A medical condition (including severe pain) that would lead you to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus (including a pregnant woman in active labor)

A mental health condition is also an **emergency medical condition** when, due to a **mental disorder**, either of the following is true:

- You are an immediate danger to yourself or to others
- You are immediately unable to provide for or use food, shelter, or clothing due to the **mental disorder**

Emergency services

Treatment given in a **hospital**'s emergency room for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition.**

Experimental or investigational

A drug, device, procedure, or treatment that we find is **experimental or investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

Formulary exclusions list

A list of **prescription drugs** not covered under the plan. This list is subject to change.

Generic prescription drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand-name product.

HMO agreement

The **HMO agreement** consists of several documents taken together. These documents are:

- The group application
- The group agreement
- The EOC(s) attached
- The schedule of benefits attached
- Any riders and amendments to the group agreement, the EOC, and the schedule of benefits

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, and physical therapists.

Home health care agency

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan

A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a **hospital** or if you are homebound.

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency

An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

Hospice care program

A program prescribed by a **physician** or other **health professional** to provide **hospice care** and supportive care to their families.

Hospice facility

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital

An institution licensed as a **hospital** by applicable state and federal laws, and is accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility

- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance abuse**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

Illness
Poor health resulting from disease of the body or mind.

Infertile or infertility
A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

Injury
Physical damage done to a person or part of their body.

Institutes of Excellence™ (IOE) facility
A facility designated by **Aetna** in the **provider directory** as Institutes of Excellence **network provider** for specific services or procedures.

Intensive Outpatient Program (IOP)
Clinical treatment provided in a facility or program provided under the direction of a **physician**. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder
This is:
- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw, or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy
A pharmacy where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of **copayments** and **coinsurance** to be paid by you or any covered dependents per **calendar year** for **eligible health services**.

Medically necessary/Medical necessity

Health care services that we determine a **provider** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

Mental disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatrist**, a psychologist or a psychiatric social worker. **Mental disorder** includes substance related disorders.

Morbid obesity/morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

Negotiated charge

*As to health coverage, (other than **prescription drug** coverage for services obtained from a **network pharmacy**):*
The amount a **network provider** has agreed to accept for rendering services or providing **prescription drugs** or supplies to members of your plan.

*As to **prescription drug** coverage when **prescription drugs** are obtained from a **network pharmacy**:*
The amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Aetna may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network pharmacy

A **retail**, **mail order** or **specialty pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

Network provider

A **provider** listed in the **directory** for your plan. However, a National Advantage Program (NAP) provider listed in the NAP directory is not a **network provider.** The NAP **network** consists of many of **Aetna**'s directly contracted **hospitals**, ancillary **providers**, and **physicians** as well as **hospitals**, ancillary **providers**, and **physicians** accessed through vendor arrangements.

Partial hospitalization treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat **mental disorders** and **substance abuse**. The treatment plan must meet these tests:

- It is carried out in a **hospital**, **psychiatric hospital** or **residential treatment facility** on less than a full-time inpatient basis.
- It is in accordance with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatrist** who weekly reviews and evaluates its effect.

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Precertification, precertify
A requirement that your **physician** contact **Aetna** before you receive coverage for certain services. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Preferred drug
A **prescription drug** or device that may have a lower out-of-pocket cost than a **non-preferred drug**.

Preferred drug guide
A list of **prescription drugs** and devices established by **Aetna** or an affiliate. It does not include all **prescription drugs** and devices. This list can be reviewed and changed by **Aetna** or an affiliate. The Therapeutics Committee reviews the **preferred drug guide** annually. Throughout the year, the Therapeutics Committee may also evaluate new drugs once they are approved by the FDA, and may re-evaluate the drugs on the current **preferred drug guide** in light of new FDA, manufacturer, and/or peer reviewed information. Further information about the Therapeutics Committee is located in the **preferred drug guide**. A copy of the **preferred drug guide** is available at your request. Or you can find it on the **Aetna** website at www.aetna.com/formulary.

Preferred network pharmacy
A **network retail pharmacy** that Aetna has identified as a **preferred network pharmacy.**

Premium
The amount you or your employer are required to pay to **Aetna** to continue coverage.

Prescriber
Any **provider** acting within the scope of his or her license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription
*As to **prescription drugs**:*
A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

Prescription drug
An FDA approved drug or biological which can only be dispensed by **prescription.**

Primary care physician (PCP)

A **physician** who:

- The **directory** lists as a **PCP** Is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care **physician,** an internist, obstetrician, gynecologist or a pediatrician
- Initiates **referrals** for **specialist** care and maintains continuity of patient care
- Is shown on **Aetna**'s records as your **PCP**

Provider
A **physician**, other health professional, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital
An institution specifically licensed as a **psychiatric hospital** by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **mental disorders** or mental illnesses.

Psychiatrist
A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

R.N.
A registered nurse.

Referral
This is a written or electronic authorization made by your **PCP** to direct you to a **network provider** for **medically necessary** services and supplies.

Residential treatment facility (mental disorders)
- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for residential treatment programs treating **mental disorders**:
- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a **psychiatrist** at least once per week.
- The medical director must be a **psychiatrist**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

Residential treatment facility (substance abuse)
- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for substance abuse residential treatment program and is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)

- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
- The medical director must be a **physician**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

In addition to the above requirements, for Chemical Dependence **Detoxification** Programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting.
- Residential care must be provided under the direct supervision of a **physician**.

Retail pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs** at retail prices.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Texas Health + Aetna Health** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service area

The geographic area where **network providers** for this plan are located.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation **hospital**s, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or

substance abuse.

Skilled nursing services
Services provided by an **R**.**N**. or **L.P.N.** within the scope of his or her license.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Step therapy
A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Substance abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder** that are a focus of attention or treatment. Or an addiction to nicotine products, food or caffeine intoxication.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Telemedicine
A telephone or internet-based consult with a **provider** that has contracted with **Aetna** to offer these services.

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Therapeutic drug class
A group of drugs or medications that have a similar or identical mode of action. Or are used for the treatment of the same or similar disease or **injury**.

Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent condition
An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Value Prescription Drugs
A group of medications determined by us that may be available at a reduced **copayment/coinsurance** and are noted on the **preferred drug guide**.

Discount programs

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service **providers**". These third party service **providers** may pay us so that they can offer you their services.

Third party service **providers** are independent contractors. The third party service **provider** is responsible for the goods or services they deliver. We are not responsible. But, we have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service **providers** for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and other incentives

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and continue participation as an **Aetna** member through incentives. You and your doctor can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, we may provide incentives based on your participation and your results. Incentives may include:

- Modifications to **copayment**, **deductible**, or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards, or
- Any combination of the above.

New Law Protects Consumers from Surprise Medical Bills

A new law created by Assembly Bill (AB) 72[i] (Bonta, Chapter 492, Statutes of 2016) protects consumers from surprise medical bills when they go to in-network facilities such as hospitals, labs or imaging centers. This new consumer protection starts July 1, 2017, and makes sure consumers only have to pay their in-network cost sharing.

Providers now cannot send consumers out-of-network bills when the consumer did everything right and went to an in-network facility.

Consumer Quick Facts:

- **No Surprise Medical Bills**: Health care consumers are no longer put in the middle of billing disputes between health plans and out-of-network providers. Consumers can only be billed for their in-network cost-sharing, when they use an in-network facility.
- **Prevents Collections**: Protects consumers from having their credit hurt, wages garnished, or liens placed on their primary residence.
- **Helps Control Health Care Costs**: Health plan payments for out-of-network services are no longer based on sticker price.

Frequently Asked Questions:

What is a surprise bill, and why would I get one?

Here are some examples of when consumers have gotten surprise bills:

- A consumer had a surgery at a hospital or outpatient surgery center in their health plan network, but the anesthesiologist was not in their health plan network. Even though the consumer did not have a choice in who their anesthesiologist was, that provider sends a bill to the consumer after the surgery. This is a surprise bill.
- A consumer goes to a lab or imaging center in their health plan network for tests and the doctor who reads the results is not in their health plan network. That doctor then bills the consumer for their services creating a surprise bill for the consumer.

Under AB 72, consumers should no longer receive these surprise bills. This means when you go to a health care facility like a hospital or a lab in your health plan network, and end up with a doctor who is not in your health plan network, they cannot charge you more than you would have to pay for an in-network doctor.

What should I pay?

Consumers who go to an in-network facility only have to pay for in-network cost-sharing (co-pays, co-insurance, or deductibles). Consumers should contact their health plan if they have questions about their in-network cost-sharing.

What is a Health Plan Network?

A health plan network is the group of doctors, hospitals and other health care providers a health plan contracts with to provide health care services to its members. These providers are called "network providers," "contracted providers" or "in-network providers." A provider who does not contract with your health plan is called an "out-of- network provider" or "non-contracted providers."

Examples of health care facilities that are in a health plan network include hospitals, ambulatory surgery centers or other outpatient settings, laboratories, and radiology or imaging centers.

What If I Received a Surprise Bill? And what if I Already Paid?

If you received a surprise bill and already paid more than your in-network cost share (co-pay, co-insurance or deductible), file a grievance/complaint with your health plan with a copy of the bill. Your health plan will review your grievance and should tell the provider to stop billing you. If you do not agree with your health plan's response or they take more than 30 days to fix the problem, you can file a complaint with the Department of Managed Health Care, the state regulator of health plans. You can file a complaint by visiting www.HealthHelp.ca.gov or calling **1-888-466-2219**.

Does the New Law Apply to Everyone?

The law applies to people in health plans regulated by the Department of Managed Health Care or the California Department of Insurance. It does not apply to Medi-Cal plans, Medicare plans or "self-insured plans." If you do not know what kind of plan you are in you can call the Help Center at **1-888-466-2219** for help.

What If I Want to See a Doctor Who I Know is Out-of-Network?

If you are in a health plan with an out-of-network benefit, such as a PPO, you can choose to go to an out-of-network provider. You have to give your permission by signing a form in writing at least 24 hours before you receive care. The form should inform you that you can receive care from an in-network provider if you so choose. The form should be in your language if you speak English, Spanish, Vietnamese, Cantonese, Armenian, Russian, Mandarin, Tagalog, Korean, Arabic, Hmong, Farsi, or Cambodian.

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[i] AB 72 protects consumers receiving non-emergency services at in-network facilities from being balanced billed by an out-of-network provider. California law already protects most consumers from balance billing for emergency services.

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

The Office of Civil Rights recently issued a Non-discrimination Rule in response to Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination because of race, color, national origin, sex, age or disability in health-related insurance or other health-related coverage. This applies to Aetna. Changes to health insurance plans are effective on the first day of the policy or plan year beginning on or after January 1, 2017.

Some language changes may not be in the enclosed certificate of coverage or policy. This may be because the language is still under official review for approval. See the *Important note* below for how this affects your policy or plan.

Important note:
We will comply with the requirements of the Rule for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Below is a summary of some of the recent Non-discrimination Rule changes.

An insurer covered by the Rule that provides or administers health-related insurance or other health-related coverage:

- Shall not:
  - Cancel, limit or refuse to issue or renew a policy or plan
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

  to a person because of race, color, national origin, sex, age, or disability.

- Shall not:
  - Deny or limit coverage
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

  to a transgender person, if it results in discrimination against that person.

- Shall not exclude or limit health services related to gender transition.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates. Aetna companies that receive funds from the federal Department of Health and Human Services are subject to the Rule.

Important Information About Your Plan

Coverage of Applied Behavior Analysis
For the Treatment of Autism Spectrum Disorder

Your Plan includes coverage for the diagnosis and treatment of autism spectrum disorder. Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis and treatment of autism spectrum disorder.

As part of this coverage, we will cover certain early intensive behavioral interventions, such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That are responsible for observable improvements in behavior.

Applied behavioral analysis will be subject to the same cost sharing requirements as other, outpatient services provided by a behavioral health provider for the treatment of autism spectrum disorder.

Important notes:

For plans that did not include such coverage previously, applied behavior analysis for the treatment of autism spectrum disorder will be an eligible health service for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Applied behavior analysis requires precertification by Aetna.

Aetna Health of California Inc.
Rider

Incentive

Rider effective date: January 01, 2019

This incentive rider is added to your evidence of coverage (EOC). This rider is subject to all of the requirements described in your EOC. This rider describes your incentive benefit, subject to the following requirements:

What you need to know about your incentive benefit

Read this rider carefully so that you know:

- What an incentive is
- Your incentive benefits

What an incentive is

You and your covered dependent spouse, or domestic partner, may earn a reward for participating in certain activities listed below. In order to receive your incentive all of the following steps must be done:

- Log onto your secure member website at www.aetna.com and access the Redbrick Compass® site or call the toll-free Member Services number on your member ID card.
- Complete a health assessment. A health assessment is a comprehensive questionnaire that can help you learn more about your health risks and how you can control them. A series of questions will be asked about things such as blood pressure, cholesterol levels, triglyceride level and blood sugar. This information can be obtained from your doctor during your annual physical.
- After you complete your health assessment, you will be eligible to participate in activities that align with your results. A list of these activities is available from us or your contract holder. To contact us, log onto your secure member website at www.aetna.com, or call Member Services at the number on your ID card.
- Once you complete your health assessment and one activity, you will receive your incentive amount. The type and value of your incentive amount and the incentive maximum are chosen by the contract holder**.**
- The incentive amount is shown in the schedule of benefits below.

Your plan may also have an incentive maximum per **calendar year**. The incentive amount and the incentive maximum are shown in the schedule of benefits below.

Schedule of benefits

Your incentive benefits

Plan features	Incentive amount/Maximums
Incentive amount	$50 per **calendar year**.
Individual incentive maximum	$50 per **calendar year**.
Family incentive maximum	$100 per **calendar year**.

AETNA HEALTH OF CALIFORNIA INC.
Rider

Outpatient prescription drug plan

Rider effective date: January 01, 2019

This **prescription** plan rider is added to your evidence of coverage (EOC). This rider is subject to all of the requirements described in your EOC. This rider describes your outpatient **prescription drug** plan benefit, subject to the following requirements:

What you need to know about your outpatient prescription drug plan

Read this rider carefully so that you know:

- How to access **network pharmacies**
- **Eligible health services** under your plan
- What outpatient **prescription drugs** are covered
- Other services
- How you get an emergency **prescription** filled
- Where your schedule of benefits fits in
- What **precertification** requirements apply
- What your plan doesn't cover – some **eligible health service** exceptions
- How you share the cost of your outpatient **prescription drugs**

Some **prescription drug**s may not be covered or coverage may be limited. This does not keep you from getting **prescription drug**s that are not **covered benefits**. You can still fill your **prescription**, but you have to pay for it yourself. For more information see the *Where your schedule of benefits fits in* section, and see the schedule of benefits.

A **pharmacy** may refuse to fill a **prescription** order or refill when in the professional judgment of the pharmacist the **prescription** should not be filled.

How to access network pharmacies

How do you find a network pharmacy?

You can find a network pharmacy in two ways:

- **Online:** By logging onto your secure member website at www.aetna.com.
- **By phone:** Call the toll-free Member Services number on your member ID card. During regular business hours, a Member Services representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

You may go to any of our **network pharmacies**. **Pharmacies** include **network retail**, **mail order** and **specialty pharmacies**.

What if the pharmacy you have been using leaves the network?
Sometimes a **pharmacy** might leave the network. If this happens, you will have to get your **prescriptions** filled at another **network pharmacy**. You can use your **provider directory** or call the toll-free Member Services number on your member ID card to find another **network pharmacy** in your area.

Eligible health services under your plan

What does your outpatient prescription drug plan cover?
Any **pharmacy** service that meets these three requirements:

- They are listed in the *Eligible health services under your plan* section.
- They are not carved out in the *What your plan doesn't cover - some eligible health service exceptions* section.
- They are not beyond any limits in the schedule of benefits below.

Your plan benefits are covered when you follow the plan's general rules:

- You need a **prescription** from your **prescriber.**
- Your drug needs to be **medically necessary** for your **illness** or **injury.** See the *Medical necessity , referral and precertification requirements* section.
- You need to show your ID card to the **pharmacy** when you get a **prescription** filled.

Your outpatient **prescription drug** plan includes drugs listed in the **drug guide. Prescription drugs** listed on the **formulary exclusions list** are excluded unless a medical exception is approved by us prior to the drug being picked up at the pharmacy. If it is **medically necessary** for you to use a **prescription drug** on the **formulary exclusions list**, you or your **prescriber** must request a medical exception.

The **drug guide (formulary)** contains drugs that have been reviewed by **Aetna**'s Pharmacy and Therapeutics Committee. This Committee:

- Reviews the entire **drug guide (formulary)** at least annually.
- Meets regularly to review new drugs and new information about drugs that already are in the marketplace.
- Reviews available information concerning safety, effectiveness, and current use in therapy.
- Reviews information from a variety of sources, including:
  - Peer reviewed journals and databases such as DrugPoints, American Hospital Formulary Service Drug Information (AHFS-DI), DrugDex, clinical pharmacology, Medline, national guidelines
  - Information from medical professional associations, national commissions, and federal government agencies

Using this information, the Committee evaluates the therapeutic effectiveness of new **prescription** medications and places them into one of six categories:

- **Category 1 –** important therapeutic advance
  - Provides effective therapy for a disease not adequately treated by any marketed drug, or improved effectiveness or safety.
  - Products in this category will be included on **drug guide (formulary)**, regardless of cost factors.
  - **Precertification** may or may not be recommended.

- **Category 2, 2+, 2-**

- **Category 2 –** therapeutically similar to other available products
  - Clinical differences are not significant, or appear be counterbalanced between products.

- **Category 2+ –** therapeutically similar to other available products but has clinical advantages (clinical efficacy, adverse effects, drug interactions, etc.) to others in the category.

- **Category 2- –** therapeutically similar to other available products but has clinical disadvantages (clinical efficacy, adverse effects, drug interactions, etc.) to others in the category.

- **Category 3 –** not appropriate for **drug guide (formulary)**
  - Has significant disadvantages in safety or efficacy in comparison to other available self-administered products.
  - Products in this category will not be added to **drug guide (formulary)**, regardless of cost factors.

- **Category 4 -** niche products
  - May have an important role for certain patient populations or as second or third-line alternatives (sometimes known as "niche" products).
  - At a minimum, these products must be available through **precertification** or **step therapy** for these uses.

We will make a decision to include or not include drugs on the **drug guide (formulary)** based on these categories. For a therapeutically similar drug, we will select drugs based on:

- The six categories (clinical ranking: efficacy/safety)
- Cost of effectiveness of medication
- Other factors (regulations)

A copy of the **drug guide (formulary)** or information about the availability of a specific drug may be requested by calling 1-800-414-2386. The **drug guide (formulary)** may also be accessed through our Internet website at www.aetna.com. The presence of a drug on the **drug guide (formulary)** does not guarantee that you will receive a **prescription** for that drug from your **prescriber** for a particular medical condition. **Precertification**, may be necessary for coverage of certain **prescription drugs**. See the *Precertification* section.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your **provider**, and/or your **network pharmacy**. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one **network pharmacy**, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage.

What prescription drugs are covered

Your **prescriber** may give you a **prescription** in different ways, including:

- Writing out a **prescription** that you then take to a **network pharmacy.**
- Calling or e-mailing a **network pharmacy** to order the medication.
- Submitting your **prescription** electronically.

Once you receive a **prescription** from your **prescriber**, you may fill the **prescription** at a **network retail**, **mail order** or **specialty pharmacy.**

Retail pharmacy
Generally, **retail pharmacies** may be used for up to a 30 day supply of **prescription drugs**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will submit your claim. You will pay any cost sharing directly to the **network pharmacy**.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

See the schedule of benefits below for details on supply limits and cost sharing.

Mail order pharmacy
Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition.

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

See the schedule of benefits below for details on supply limits and cost sharing.

Specialty pharmacy
Specialty prescription drugs are covered when dispensed through a **network retail or specialty pharmacy.**

Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. You can access the list of **specialty prescription drugs** by contacting Member Services by logging onto your secure member website at www.aetna.com or calling the number on the back of your ID card.

All **specialty prescription drugs** fills after the initial fill must be filled at a **network specialty pharmacy** except for urgent situations.

See the schedule of benefits for details on supply limits and cost sharing.

Other services

Preventive Contraceptives
For females who are able to reproduce, your outpatient **prescription drug** plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the

methods identified by the FDA at no cost share. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** or device for that method at no cost share.

Important Note: You may qualify for a medical exception if your provider determines that the contraceptives covered standardly as preventive are not medically appropriate. Your prescriber may request a medical exception and submit the exception to us.

Diabetic supplies

Eligible health services include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

See your medical plan benefits for coverage of blood glucose meters and insulin pumps

Infertility drugs

Eligible health services include oral synthetic ovulation stimulant **prescription drugs** used primarily for the purpose of treating the underlying cause of **infertility**.

Off-label use

U.S. Food and Drug Administration (FDA) approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your symptom(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your symptom(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
  - Thomson Micromedex DrugDex System (DrugDex)
  - Clinical Pharmacology (Gold Standard, Inc.)
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or
- Use for your symptom(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your symptom(s) is equal to the dosage for the same symptom(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above, or
  - The dosage has been proven to be safe and effective for your symptom(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to **precertification**, **step therapy** or other requirements or limitations.

Orally administered anti-cancer drugs, including chemotherapy drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Pain management for the terminally ill

Eligible health services include pain management outpatient **prescription drugs** for a terminally ill covered person

Pediatric asthma services and supplies

Eligible health services include outpatient self-management training, education and the following supplies for a child:

- Nebulizers, including face masks and tubing
- Inhaler spacers
- Peak flow meters

Preventive care drugs and supplements

Eligible health services include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the ACA guidelines when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Risk reducing breast cancer prescription drugs

Eligible health services include **prescription drugs** when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing for a woman who is at:

- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Sexual dysfunction/enhancement

Eligible health services include **prescription drugs** for the treatment of sexual dysfunction/enhancement.

For the most up-to-date information on dosing, call the toll-free number on your ID card.

Tobacco cessation prescription and over-the-counter drugs

Eligible health services include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

How you get an emergency prescription filled

You may not have access to a **network pharmacy** in an emergency or urgent care situation, or you may be traveling outside of the plan's **service area.** If you must fill a **prescription** in either situation, we will reimburse you as shown in the table below.

Type of pharmacy	Your cost share
Network pharmacy and out-of-area **network pharmacy**	• You pay the **copayment**.
Out-of-network pharmacy	• You pay the **pharmacy** directly for the cost of the **prescription**. Then you fill out and send a **prescription drug** refund form to

	us, including all itemized **pharmacy** receipts. • Coverage is limited to items obtained in connection with covered emergency and out-of-area urgent care services. • You must access a **network pharmacy** for urgent care **prescriptions** inside the **service area.** • Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your **prescription** less your **copayment/ coinsurance**.

Where your schedule of benefits fits in

You are responsible for paying your part of the cost sharing. The schedule of benefits below shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

Your **prescription drug** costs are based on:

- The type of **prescription** you use, (**generic, brand-name**, **biosimilar**, **preferred**, **non-preferred**, **specialty, injectable**, and self-injectable **prescription drugs**).
- Where you fill your **prescription**, (at a **network retail**, **mail order** or **specialty pharmacy**).

Let us help you understand how the cost sharing works.

How your copayment/coinsurance works

Your **copayment/coinsurance** is the amount you pay for each **prescription** fill or refill. Your schedule of benefits shows you which **copayments/coinsurance** you need to pay for specific **prescription** fill or refill. You will pay any cost sharing directly to the **network pharmacy**.

How your outpatient prescription drug maximum out-of-pocket limit works

You will pay your outpatient **prescription drug copayments/coinsurance** up to the outpatient **prescription drug maximum out-of-pocket limit** for your plan.

Your schedule of benefits shows the outpatient **prescription drug maximum out-of-pocket limits** that apply to your plan. Once you reach your outpatient **prescription drug maximum out-of-pocket limit**, your plan will pay for outpatient **prescription drug covered benefits** for the remainder of that calendar year.

What precertification requirements apply

Why do some drugs need precertification?

For certain drugs, your **prescriber** or your pharmacist needs to get approval from us before we will cover the drug. This is called **"precertification."** The requirement for getting approval in advance guides appropriate use of precertified drugs and makes sure they are **medically necessary**. For the most up-to-date information, call the toll-free number on your member ID card or log on to your secure member website at www.aetna.com.

There is another type of **precertification** for **prescription drugs** and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You will find the **step therapy prescription drugs** on the **drug guide.** For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your secure member website at www.aetna.com.

The chart below shows the different types of **precertification** requests and how much time we have to tell you about our decision.

Type of request	Standard (non-urgent)	Exigent circumstances
Initial decision by us	72 hours	As soon as possible, but no longer than 24 hours
If we need more information, we will notify you within	Not applicable	24 hours
Once we have more information, our decision will be made	Not applicable	24 hours
How long the drug will be covered if request is approved	As long as it is prescribed, including refills	As long as it is prescribed, including refills

A request under exigent circumstances can be made when:

- Your condition may seriously affect your life, health, or ability to get back maximum function
- You are going through a current course of treatment using a **non-preferred drug**

What if my precertification request is denied?

If **precertification** request of a **non-preferred drug** and/or **step therapy** exception request, you can file a grievance seeking an external exception review. For more information see the *When you disagree – claim decisions and appeals procedures* section in the EOC.

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not listed on the **drug guide** or for **brand-name, specialty** or **biosimilar prescription drugs** or for which health care services are denied through **precertification**, **step therapy.** You or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons. If approved by us, you will receive the **preferred drug** benefit level. See the schedule of benefits below for details on cost sharing.

Prescribing units

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your **prescription drug** is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these quantity limits.

Any **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

Specialty prescription drugs are limited to no more than a 30 day supply.

What your plan doesn't cover – some eligible health service exceptions

In this section we tell you about the exceptions. These **prescription drug** exceptions are in addition to the exceptions listed in the EOC. If you receive any services listed in this section or in the EOC, they will not be covered.

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug, except as specifically provided in the *Eligible health services under your plan – Physicians and other health professionals section*.

Biological sera

Cosmetic drugs

- Medications or preparations used for cosmetic purposes.

Devices, products and appliances, except those that are specifically covered

Dietary supplements including medical foods except as specifically provided in the *Eligible health services under your plan – Other services* section

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or dispensed. except as **medically necessary** to treat withdrawal symptoms as part of ambulatory detoxification
- Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written. See the *Eligible health services under your plan – Outpatient* section.
- That includes the same active ingredient or a modified version of an active ingredient.
- That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved).
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan or while an inpatient of a healthcare facility
- That include methadone maintenance medications used for drug detoxification
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies.

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunizations related to travel or work

Immunization or immunological agents

Infertility

- **Injectable prescription drugs** used primarily for the treatment of **infertility.**

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us except as specifically provided in the Eligible health services under your plan – Physicians and other health professionals section.
- Needles and syringes, except for those used for self-administration of an injectable drug
- For any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps see the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.

Prescription drugs:

- Dispensed by other than a **network retail**, **mail order** and **specialty pharmacies**
- Dispensed by an **out-of-network mail order pharmacy**, except in a medical emergency or urgent care situation.
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this rider.
- Dispensed by a **mail order pharmacy** that includes **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the plan.
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug** guide.
- That are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are not considered covered or related to a non-covered service.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Refills

- Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

Schedule of benefits

How you share the cost of your outpatient prescription drugs

This schedule of benefits lists the **copayments/coinsurance**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from **network providers**.
- You are responsible to pay any **copayments/coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be supply limit maximums.

Important note:
All **covered benefits** are subject to the **calendar year copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

Plan features	Copayment/Coinsurance Maximums

Outpatient prescription drug maximum out-of-pocket limit
Outpatient prescription drug maximum out-of-pocket limit per **calendar year**

Individual	$3,500 per calendar year
Family	$7,000 per calendar year

Eligible health services	In-network coverage

Preferred generic prescription drugs
Per prescription copayment/coinsurance

For each fill up to a 30 day supply filled at a **retail pharmacy**	$10 **copayment** per supply

More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$20 **copayment** per supply

Non-preferred generic prescription drugs **Per prescription copayment/coinsurance**

For each fill up to a 30 day supply filled at a **retail pharmacy**	$50 **copayment** per supply

More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$100 **copayment** per supply

Preferred brand-name prescription drugs **Per prescription copayment/coinsurance**

For each fill up to a 30 day supply filled at a **retail pharmacy**	$30 **copayment** per supply

More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$60 **copayment** per supply

Non-preferred brand-name prescription drugs **Per prescription copayment/coinsurance**

For each fill up to a 30 day supply filled at a **retail pharmacy**	$50 **copayment** per supply

More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$100 **copayment** per supply

Diabetic supplies and insulin **Per prescription copayment/coinsurance**

For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits, above

More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits, above

Orally administered anti-cancer prescription drugs including specialty prescription drugs **Per prescription copayment/coinsurance**	
For each fill up to a 30 day supply filled at a **retail**	$0 **copayment** per supply

pharmacy	

More than a 31 day supply but less than 91 supply filled at a **mail order pharmacy**	$0 **copayment** per supply

Pediatric asthma services and supplies	
Per prescription copayment/coinsurance	
For each 30 day supply	Paid according to the type of drug per the schedule of benefits, above

Specialty prescription drugs
Per prescription copayment/coinsurance

For each fill up to a 30 day supply filled at a **retail pharmacy**	**Coinsurance** per supply is 20% (of the Plan's cost) but will be no more than $200

Preventive care drugs and supplements

Preventive care drugs and supplements filled at a **pharmacy** For each 30 day supply	$0

Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on the back of your ID card.

Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy** For each 30 day supply	$0

Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on the back of your ID card.

If a **prescriber** prescribes a covered **brand-name prescription drug** where **a generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If a **prescriber** does not specify DAW and you request a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available you will be responsible for the cost difference between **the brand-name prescription drug** and the **generic prescription drug** equivalent, and the cost sharing that applies to **brand-name prescription drugs**. The DAW charge is not applied towards your calendar year **prescription drug maximum out-of-pocket limit**.

Tobacco cessation prescription and over-the-counter drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** For each 90 day supply	$0 per **prescription** or refill

Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on the back of your ID card.

General coverage provisions

This section provides detailed explanations about the:

- Outpatient **prescription drug maximum out-of-pocket limits**

Outpatient prescription drug maximum out-of-pocket limits provisions
Eligible health services that are subject to the **maximum out-of-pocket limit** include **eligible health services** provided under the medical plan and the outpatient **prescription drug** plan rider.

The outpatient **prescription drug maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/coinsurance** for **eligible health services** during the **calendar year**. This plan has an individual and family outpatient **prescription drug maximum out-of-pocket limit**.

Individual Once the amount of the **copayments/coinsurance** you and your covered dependents have paid for **eligible health services** during the **calendar year** meets the individual outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of the **covered benefits** that apply toward the limit for the rest of the **calendar year** for that person.

Family
Once the amount of the **copayments/coinsurance** you and your covered dependents have paid for **eligible health services** during the **calendar year** meets this family outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of such **covered benefits** that apply toward the limit for the remainder of the **calendar year** for all covered family members.

To satisfy this family outpatient **prescription drug maximum out-of-pocket limit** for the rest of the **calendar year** the following must happen:

- The family outpatient **prescription drug maximum out-of-pocket limit** is a cumulative outpatient **prescription drug maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual outpatient **prescription drug maximum out-of-pocket limit** amount in a **calendar year**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayment/coinsurance** for **eligible health services** during the **calendar year**. This plan has an individual and family outpatient **prescription drug maximum out-of-pocket limit**.

Costs that you incur that do not apply to your outpatient **prescription drug maximum out-of-pocket limit.**

Certain costs that you incur do not apply toward the outpatient **prescription drug maximum out-of-pocket limit**. These include:

- All costs for non-covered services

Aetna Health of California Inc.
Health Maintenance Organization (HMO)
Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact the contract holder for additional information.

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

Schedule of benefits

This schedule of benefits lists the **copayments/coinsurance**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- When we say "in-network coverage", we mean you get care from **network providers**.
- The **copayments/coinsurance** listed in the schedule of benefits below reflects your **copayment/coinsurance** amounts.
- You are responsible to pay any **copayments/coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the member pays. The plan is responsible for paying any remaining **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums.
- At the end of this schedule you will find detailed explanations about your:
  - **Maximum out-of-pocket limits**
  - Maximums

Important note:
All **covered benefits** are subject to the calendar year **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your secure member website at www.Aetna.com or at the toll-free number on your ID card.

The coverage described in this schedule of benefits will be provided under Aetna Health of California Inc.**'s HMO agreement**. This schedule of benefits replaces any schedule of benefits previously in effect under the **HMO agreement**. Keep this schedule of benefits with your EOC.

Plan features	**Maximums**
	In-network coverage*

Maximum out-of-pocket limit
Maximum out-of-pocket limit per **calendar year**

Individual	**$3,500** per **calendar year**
Family	**$7,000** per **calendar year**

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*
1. Preventive care and wellness	
Routine physical exams	
Performed at a **physician's, PCP** office	$0 per visit
	No **deductible** applies
Covered persons through age 22: Maximum age and visit limits per **12 months**	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your secure member website at www.aetna.com or calling the number on the back of your ID card.
Covered persons age 22 and over: Maximum visits per **12 months**	1 visit
Preventive care immunizations	
Performed in a facility or at a **physician's** office	$0 per visit
	No **deductible** applies
Limited to: Covered persons through age 22 Covered persons age 22 and over but less than 65 Covered persons age 65 and over	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician** or Member Services by logging onto your secure member website at www.aetna.com or calling the number on the back of your ID card.

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

Well woman preventive visits routine gynecological exams (including pap smears)	
Performed at a **physician's, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	$0 per visit
	No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per **365 Days**	1 visit(s)

Preventive screening and counseling services	
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	 $0 per visit $0 per visit $0 per visit $0 per visit $0 per visit
	No **deductible** applies

Obesity and/or healthy diet counseling maximums:	
Maximum visits per day (This maximum applies only to covered persons age 22 and older.)	1 visit*
Maximum visits per **calendar year** (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Misuse of alcohol and/or drugs maximums:	
Maximum visits per day	1 visit*
Maximum visits per **calendar year**	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Use of tobacco products maximums:	
Maximum visits per day	1 visit*
Maximum visits per **calendar year**	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Sexually transmitted infection counseling maximums:	
Maximum visits per **calendar year**	2 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Genetic risk counseling for breast and ovarian cancer maximums:	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)	
Routine cancer screenings	$0 per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

	No **deductible** applies

Lung cancer screening maximum	1 screening(s) every 12 month(s)*
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section**.**	

Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**	
Preventive care services only	$0 per visit
	No **deductible** applies

Comprehensive lactation support and counseling services	
Lactation counseling services - facility or office visits	$0 per visit
	No **deductible** applies
Lactation counseling services maximum visits per **calendar year** either in a group or individual setting	6 visits*
Important note: Any visits that exceed the lactation counseling services maximum are covered under ***physician*** *services* office visits.	

Breast feeding durable medical equipment	
Breast pump supplies and accessories	$0 per item
	No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the certificate for limitations on breast pump and supplies.	

Family planning services – female contraceptives	
Female contraceptive counseling services office visit	$0 per visit
	No **deductible** applies

Counseling services	
Contraceptive counseling services maximum visits per **calendar year** either in a group or individual setting	2 visit(s)*
Important note: Any visits that exceed the contraceptive counseling services maximum are covered under *Physician services* office visits.	

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

Devices	
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	$0 per visit
	No **deductible** applies

Female voluntary sterilization	
Inpatient	$0 per visit
	No deductible applies
Outpatient	$0 per visit
	No deductible applies

Eligible health services	**In-network coverage***
2. Physicians and other health professionals	

Physicians and **specialists** office visits (non-surgical)	
Physician services	
Office hours visits (non-surgical) non preventive care	$45 per visit
	No **deductible** applies
Telemedicine consultation by a **physician, PCP**	$45 per visit
	No **deductible** applies
Telemedicine consultation by a **specialist**	$65 per visit
	No **deductible** applies

Allergy injections	
Performed at a **physician's, PCP** or **specialist** office when you see the **physician**	Covered according to the type of benefit and the place where the service is received.
Allergy testing and treatment	
Performed at a **physician's, PCP** or **specialist** office	Covered according to the type of benefit and the place where the service is received.

Immunizations when not part of the physical exam	
Immunizations when not part of the physical exam	Covered according to the type of benefit and the place where the service is received.

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

	No **deductible** applies

Injectable medications	
Performed at a **physician's, PCP** or **specialist** office	Covered according to the type of benefit and the place where the service is received.

	No **deductible** applies

Specialist office visits	
Office hours visit (non-surgical)	$65 per visit

	No **deductible** applies

Eligible health services	In-network coverage*
3. Hospital and other facility care	

Hospital care	
Inpatient **hospital** (**room and board**)	$2,000 per admission
	No **deductible** applies

Anesthesia and hospital charges for dental care	
Anesthesia and hospital charges for dental care	Covered according to the type of benefit and the place where the service is received

Alternatives to hospital stays

Outpatient surgery and physician surgical services

	$500 per visit
	No **deductible** applies
Performed at a **physician, PCP** or **specialist** office	Covered according to the type of benefit and the place where the service is received.
	No **deductible** applies

Home health care	
Outpatient	$65 per visit
	No **deductible** applies
Maximum visits per **calendar year**	120 visits Limited to: 3 intermittent visit(s) per day provided by a participating home health care agency; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of (3 visits).

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

Hospice care	
Inpatient facility (**room and board**)	$2,000 per admission

	No **deductible** applies

Hospice care	
Outpatient	$65 per visit

	No **deductible** applies

Skilled nursing facility	
Inpatient facility (**room and board**)	$2,000 per admission

	No **deductible** applies

Eligible health services	**In-network coverage***
4. Emergency services and urgent care	

Emergency services	
Hospital emergency room	$150 per visit

	No **deductible** applies

Non-emergency care in a **hospital** emergency room	Not covered

Important note:

- As **out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share, (**deductible, copayment** and **coinsurance**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.
- A separate **hospital** emergency room **deductible** or **copayment/coinsurance** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment/coinsurance** will be waived and your inpatient **copayment/coinsurance** will apply.

Urgent care	
Urgent medical care (at a non-**hospital** free standing facility)	$35 per visit

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

	No **deductible** applies

Non-urgent use of urgent care **provider** (at a non-**hospital** free standing facility)	Not covered

A separate urgent care **deductible** or **copayment/coinsurance** will apply for each visit to an urgent care **provider**

Eligible health services	In-network coverage*
5. Specific conditions	

Diabetic equipment, supplies and education	
Diabetic equipment, supplies and education	$45 per visit
	No **deductible** applies

Family planning services - other
Voluntary Sterilization for males

Outpatient	Covered according to the type of benefit and the place where the service is received.

Gender reassignment	
Performed at inpatient **hospital**	$2,000 per admission
	No **deductible** applies
Performed in a **hospital** outpatient facility	$500 per visit
	No **deductible** applies
Performed in a facility other than a **hospital** outpatient facility	$500 per visit
	No **deductible** applies

Maternity and related newborn care	
Inpatient (**room and board**)	$2,000 per admission
	No **deductible** applies
Any copayment that is collected applies to the delivery and postpartum care services provided by an OB, GYN, or OB/GYN only. No copayment that is collected applies to prenatal care services provided by an OB, GYN, or OB/GYN.	
See the *Prenatal care* section for cost-sharing and maximums that apply to these services.	

Delivery services and postpartum care services	
Performed in a facility or at a **physician's** office	$45 per visit
	No **deductible** applies

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

Other prenatal care services	Covered according to the type of benefit and the place where the service is received

Mental health treatment Coverage is provided under the same terms, conditions as any other **illness**.	
Mental health treatment - inpatient	
Inpatient mental health treatment during a **hospital** confinement (**room and board**)	$2,000 per admission
	No **deductible** applies
Other inpatient mental health treatment services and supplies during a **hospital** confinement (other than **room and board**)	$2,000 per admission
	No **deductible** applies
Residential treatment - inpatient	
Inpatient **residential treatment facility** during a **hospital** confinement **(room and board)**	$2,000 per admission
	No **deductible** applies
Mental health treatment - outpatient	
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** (and **telemedicine** consultation*)	$65 per visit
	No **deductible** applies
Outpatient – all other services (as described in your EOC)	$0 per visit
	No **deductible** applies

*Your plan covers **telemedicine** only when you get your telephone or internet-based consult through an authorized internet service vendor who conducts **telemedicine** consultations that has contracted with **Aetna** to offer these services. DocFind® tells you who those are.

Substance related disorders treatment Coverage is provided under the same terms, conditions as any other **illness.**

Detoxification - inpatient	
Inpatient **substance abuse detoxification** during a **hospital** confinement (**room and board)**	$2,000 per admission
	No **deductible** applies

Substance related disorders treatment - outpatient	
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider**	$65 per visit
	No **deductible** applies

Rehabilitation - inpatient	
Inpatient **substance abuse** rehabilitation during a **hospital** confinement (room and board)	$2,000 per admission
	No **deductible** applies

Residential treatment - rehabilitation	
Inpatient **residential treatment facility** during a **hospital** confinement (**room and board**)	$2,000 per admission
	No **deductible** applies

Residential treatment - rehabilitation	
Other Inpatient **residential treatment facility** services and supplies during a **hospital** confinement (other than **room and board**	$2,000 per admission
	No **deductible** applies
Outpatient – all other services (as described in your EOC)	$0 per visit
	No **deductible** applies

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

Reconstructive breast surgery	
Reconstructive breast **surgery**	Covered according to the type of benefit and the place where the service is received.
	No **deductible** applies

Reconstructive surgery and supplies	
Reconstructive **surgery** and supplies	Covered according to the type of benefit and the place where the service is received.
	No **deductible** applies

Eligible health services	**Network (IOE facility)**	**Network (Non-IOE facility)**
Transplant services facility and non-facility		
Inpatient **hospital** transplant services (**room and board**)	$2,000 per admission	Not covered
	No **deductible** applies	Not covered
Outpatient		
	$500 per transplant	Not covered
	No **deductible** applies	
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Not covered

Eligible health services	**In-network coverage***
Treatment of basic infertility	
Basic **infertility**	Covered according to the type of benefit and the place where the service is received

Eligible health services	**In-network coverage***
6. Specific therapies and tests	
Outpatient diagnostic testing	
Diagnostic complex imaging services	
Performed in the **hospital** outpatient department of a **hospital**	$150 per visit
	No **deductible** applies

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

Performed at an outpatient facility other than the **hospital** outpatient department of a **hospital**	$150 per visit
	No **deductible** applies

Diagnostic lab work	
Performed in the **hospital** outpatient department of a **hospital**	$0 per visit
	No **deductible** applies
Performed at an outpatient facility other than the **hospital** outpatient department of a **hospital**	$0 per visit
	No **deductible** applies

Diagnostic radiological services	
Performed in the **hospital** outpatient department of a **hospital**	$0 per visit
	No **deductible** applies
Performed at an outpatient facility other than the **hospital** outpatient department of a **hospital**	$0 per visit
	No **deductible** applies

Chemotherapy	
Chemotherapy	Covered according to the type of benefit and the place where the service is received.
	No **deductible** applies

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Outpatient infusion therapy	
Performed in a **physician's** office	Covered according to the type of benefit and the place where the service is received.
Performed at a preferred infusion location	Covered according to the type of benefit and the place where the service is received.
Performed in a person's home	Covered according to the type of benefit and the place where the service is received.
Performed in the outpatient department of a **hospital**	Covered according to the type of benefit and the place where the service is received.
Performed at an outpatient facility other than the outpatient department of a **hospital**	Covered according to the type of benefit and the place where the service is received.

Specialty prescription drugs	
Performed in a **physician's** office	Covered according to the type of benefit and the place where the service is received.
Performed at a preferred infusion location	Covered according to the type of benefit and the place where the service is received.
Performed in a person's home	Covered according to the type of benefit and the place where the service is received.
Performed in the outpatient department of a **hospital**	Covered according to the type of benefit and the place where the service is received.
Performed at an outpatient facility other than the outpatient department of a **hospital**	Covered according to the type of benefit and the place where the service is received.

Outpatient radiation therapy	
Radiation therapy	Covered according to the type of benefit and the place where the service is received.

Short-term cardiac and pulmonary rehabilitation services	
Cardiac rehabilitation	
Cardiac rehabilitation	$65 per visit

	No **deductible** applies

Pulmonary rehabilitation	
Pulmonary rehabilitation	$65 per visit

	No **deductible** applies

Outpatient cognitive rehabilitation	
Outpatient cognitive rehabilitation	Covered according to the type of benefit and the place where the service is received.

Outpatient physical and occupational therapies	
	$65 per visit

*See *How to read your schedule of benefits and important note about your cost sharing* at the beginning of this schedule of benefits

	No **deductible** applies

Outpatient speech therapy	
Outpatient speech therapy	$65 per visit

	No **deductible** applies

Habilitation therapy services	
Therapies other than physical, occupational, and speech	Covered according to the type of benefit and the place where the service is received

Outpatient physical and occupational therapies	
	$65 per visit

	No **deductible** applies

Outpatient speech therapy	
Outpatient Speech therapy	$65 per visit

	No **deductible** applies

Eligible health services	In-network coverage*
7. Other services	

Acupuncture	
Acupuncture	$15 per visit
	No **deductible** applies
Maximum visits per **calendar year**	20 visits

Ambulance service	
Ground **ambulance**	$150 per trip
	No **deductible** applies
Air or water **ambulance**	$150 per trip
	No **deductible** applies

Clinical trial therapies (experimental or investigational)	
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received.
Clinical trials (routine patient costs)	
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.

Durable medical equipment (DME)	
DME	$45 per item
	No **deductible** applies

Hearing exams	
Routine hearing exams Covered persons through age 16	$0 per visit
	No **deductible** applies

Nutritional supplements	
Nutritional supplements	$45 per item
	No **deductible** applies

*See [*How to read your schedule of benefits and important note about your cost sharing*] at the beginning of this schedule of benefits

Obesity (bariatric) surgery	
Obesity (bariatric) surgery	Covered according to the type of benefit and the place where the service is received.

Orthotic devices	
Orthotic devices	$0 per item
	No **deductible** applies

Osteoporosis	
Physician's office visits	$65 per visit
	No **deductible** applies

Prosthetic devices	
Prosthetic devices	$0 per item
	No **deductible** applies

Spinal manipulation	
Spinal manipulation	$15 per visit
	No **deductible** applies
Maximum visits per **calendar year**	20 visits

Vision care

Pediatric vision care	
Routine vision exams (including refraction)	
Performed by a legally qualified ophthalmologist or optometrist	$0 per visit
	No **deductible** applies
Maximum visits per **24 months**	1 visit(s)

Adult vision care **Limited to covered person age 19 and over**
Routine vision exams (including refraction)

Performed by a legally qualified ophthalmologist or optometrist	$0 per visit

	No **deductible** applies

Maximum visits per **24 months**	1 visit(s)

General coverage provisions

This section provides detailed explanations about the:

- **Maximum out-of-pocket limits**
- Maximums

that are listed in the first part of this schedule of benefits.

Copayments

Copayment
This is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**. If **Aetna** compensates **network providers** on the basis of the reasonable amount, your cost share is based on this amount.

Per admission **copayment**
A per admission **copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

Coinsurance

The specific percentage you have to pay for a health care service listed in the schedule of benefits.

Maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan and the outpatient **prescription drug** plan rider.

Individual
Once the amount of the **copayments/coinsurance** you or your covered dependents have paid for **eligible health services** during the **calendar year** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **covered benefits** that apply toward the limit for the rest of the **calendar year** for that person.

Family
Once the amount of the **copayments/coinsurance** you or your covered dependents have paid for **eligible health services** during the **calendar year** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of such **covered benefits** that apply toward the limit for the remainder of the **calendar year** for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the **calendar year,** the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a **calendar year.**

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayment/coinsurance** for **eligible health services** during the **calendar year**. This plan has an individual and family **maximum out-of-pocket limit**.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services

Calculations; determination of negotiated charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one **calendar year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the EOC.